

Please check the box beside the name of your insurance company.

- American States    ManhattanLife Assurance    First Unum    Sun America
- Gold Cross Burial Association    Investors Consolidated    Unilife
- Loyal American    Manhattan Life    Unum    Family Life    Western United

**INDEMNIFICATION AGREEMENT**

**AUTHORIZATION TO HONOR DEBITS DRAWN BY COMPANY REFERENCED ABOVE**

To: Financial Institution named on this form.

To: \_\_\_\_\_  
(Print Name and Address of Financial Institution where Account is maintained)

In consideration of your compliance with the request and authorization of the depositor:

As a convenience to me, I hereby request and authorize you to pay and charge to my account debits drawn on my account by and payable to the order of – the company referenced above - provided there are sufficient collected funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of and rights in respect to each such debit shall be the same as if it were signed by me. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

**THE COMPANY REFERENCED ABOVE AGREES THAT:**

1. It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any debit drawn by the company referenced above to its own order in the account of such person, or from any liability to any such person or to any owner or beneficiary of any policy issued by the company referenced above in respect of which such a debit is drawn by the company referenced above, provided there are sufficient funds in such account to pay the same upon presentation, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture of a policy the premiums on which is sought to be collected by the company referenced above by such debit; and,
2. It will refund to you any amount erroneously paid by you to the company referenced above on such debit if claim for the amount of such erroneous payment is made by you within twelve months from the date of the debit on which such erroneous payment was made.

Account Title: \_\_\_\_\_

Account Number: \_\_\_\_\_

ABA Routing Number: \_\_\_\_\_

Date of Withdrawal: \_\_\_\_\_  
(Cannot select the 29<sup>th</sup>, 30<sup>th</sup>, or 31<sup>st</sup>)

Account Type:    Checking    Savings

Policy Number: \_\_\_\_\_

Signature(s) X \_\_\_\_\_

X \_\_\_\_\_

President

**PLEASE ATTACH A VOIDED CHECK**

Return the completed form to:  
P.O. Box 925688  
Houston, Texas 77292-5688

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_