Payment Authorization Agreement

Policyholder/Applicant Information

	Policy Numbers	Premium Amount	Policy Numbers	Premium Amount
Name:				
Address:				
City, State, ZIP:				
Phone:	No. of policies:		Total: $	

Deduction Information

For newly issued policies only: For ease of your policy administration, if the policy is issued, we will make the effective date of coverage the same as your selected draft date following the receipt of your application at Aflac Worldwide Headquarters. For Direct Life only, if the policy is issued, we will make the effective date of coverage the same as your selected draft date following the approval by Underwriting of your application.

Applicant's Initials

When would you like your premiums deducted?

How often? ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Please choose a month for the first deduction. _____

Please choose any day 1–28 for the first deduction. _____

☐ I choose to pay by electronic draft.

Account Holder's Name: _____

Account Holder's Address: _____

City: _____ State: _____ ZIP: _____

Routing Transit Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ Checking ☐ Savings

☐ I choose to pay by credit or debit card (only Visa, MasterCard, and American Express are accepted).

Card Holder's Name: _____

Card Holder's Address: _____ City: _____ State: ____ Zip: _____

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiration Date: ☐☐ / ☐☐

Confirmation

I authorize Aflac to initiate recurring debit entries or charges electronically to the account indicated above for the premiums due on my policy(-ies). I authorize the institution to debit or charge same to the account. I agree this authorization shall remain effective and in full force until Aflac and the institution receive written notification from me of its termination in such time and in such manner to afford Aflac and the institution a reasonable opportunity to act on it. I authorize Aflac to continue to initiate recurring debit entries or charges to the account beyond the expiration date of the debit or credit card and to automatically update the card information as necessary to continue initiating debit entries or charges.

I acknowledge and agree I provided the account information or presented the credit or debit card referenced above. I represent I own the account or have legal authority to use the account or card referenced above. I agree to indemnify Aflac, hold Aflac harmless, and defend Aflac against any and all Losses arising out of or related to allegations I did not own the account or did not have legal authority to use the account or card referenced above. Losses include damages, liabilities, deficiencies, claims, actions, judgments, settlements, interest, awards, penalties, fines, costs, and/or expenses of whatever kind, including reasonable attorneys' fees, that are incurred by Aflac.

Authorized Account/Card User's Signature: _____ Date: _____

Policyholder's/Applicant's Signature: _____ Date: _____

Agent's Signature: _____ Writing Number: _____ Date: _____
(Required if agent assisting with application)

American Family Life Assurance Company of Columbus
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1.800.99.AFLAC. (1.800.992.3522) ● aflac.com