



Request for Automatic Payment Plan (PAC)

1-800-554-0092
Fax: 1-866-521-7902

Note: This form allows your financial institution to pay the premiums for you automatically. **Send this form and voided check to the Home Office.**

Authorization to withdraw funds by Philadelphia American Life Insurance Company. As a convenience to me, I authorize you to make payments to Philadelphia American Life Insurance Company by withdrawing funds from my account by check, draft or automatic debit entry. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. This authorization is to remain in effect until you receive notice from me to revoke it.

X _____ **X** _____
DATE NAME OF INSURED (Please Print)

Financial Institution _____

Routing No. _____

Account No _____

X _____
AUTHORIZED SIGNATURE AS SHOWN ON ACCOUNT

Policy Number **X** _____

Withdraw on the due date of my policy.

Withdraw on the following date: _____

Withdraw from my:

Checking Account Savings Account Other

Withdraw from my account:

Monthly Quarterly Semi-annually Annually