

The Prudential Insurance Company of America  
Long Term Care Customer Service Center  
P.O. Box 8519, Philadelphia, PA 19176-9816 • 1-800-732-0416

# Electronic Funds Transfer Authorization

## INSTRUCTIONS

To enroll in Prudential's monthly electronic funds transfer (EFT) payment service, please provide us with the following information. **If you wish to use your checking account, enclose your blank, voided check for that account. If you wish to use your savings account, you must confirm that your financial institution permits electronic fund withdrawals from savings accounts, and obtain your financial institution's transit routing number.** Please note that we cannot obtain acceptable banking information from deposit slips. If you have any questions, please call our Long Term Care Customer Service Center, toll free, at 1-800-732-0416. Please print except where signatures are required. Use blue or black ink.

## A APPLICANT/INSURED INFORMATION

Complete information for each applicant for whom this EFT Authorization will be used.

Full name \_\_\_\_\_

Policy/Cert.No. (If known) \_\_\_\_\_

Full name \_\_\_\_\_

Policy/Cert.No. (If known) \_\_\_\_\_

Please indicate the bill date you prefer:  1st\*  8th  15th  22nd \*If no choice indicated, this will be the bill date.

## B BANKING INFORMATION

Name of financial institution \_\_\_\_\_

Type of account  Checking  Savings

Account number \_\_\_\_\_

Full name of account owner \_\_\_\_\_

(If other than applicant/insured) \_\_\_\_\_

## C EFT PAYMENT SERVICE AUTHORIZATION

I hereby request and authorize The Prudential Insurance Company of America (Prudential) to make electronic fund withdrawals or other forms of pre-authorized withdrawals from my account named above, for payment of the premium due under the policy(ies) or certificate(s) indicated above. My signature below is exactly as it appears in my financial institution's records for this account. I agree that withdrawals shall be made approximately 3 to 5 days after the bill date indicated above. I understand that premium notices will not be mailed. I understand that if a withdrawal request is not honored by my financial institution, Prudential shall consider that my premium has not been paid. Any withdrawal returned due to insufficient funds may be re-deposited for collection by Prudential, at its sole discretion.

If this authorization pertains to insurance (or an increase in insurance) for which an application is pending, this authorization shall take effect on the Effective Date of the insurance applied for. This authorization shall not be construed as: (a) an approval by Prudential of that application; or (b) a modification of any provisions of any existing coverage. Otherwise, this authorization shall take effect on the date signed.

Either I or Prudential may cancel this authorization at any time by giving 30 days written notice to the other party. Any notice hereunder will not be deemed effective until Prudential has had a reasonable time to act. I agree that Prudential shall not be liable for any loss, liability, cost or expense for acting on this authorization.

Full name of account owner \_\_\_\_\_

Address (No P.O. Boxes please) \_\_\_\_\_

Apt. \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP \_\_\_\_\_

**X** Applicant's signature \_\_\_\_\_

Date \_\_\_\_\_

(Must be the same as that on file with the Financial Institution)

 Prudential Financial

GRP 112215 Please sign and return this copy with your application.

8/03