

Save Time & Money With Automatic Bank Withdrawal



Enrollment is easy!

1. Complete the Policyowner's Information section.
2. Sign and date the Authorization below.
3. Attach a voided check or savings deposit slip to this form.
4. Enclose your payment coupon with your premium due.
5. Mail to: **Physicians Mutual®**
PO Box 3313
Omaha, NE 68103-0313

Two faster ways to enroll!

1. **Call.** Set up your premium payment on automatic bank withdrawal over the phone by calling us at **1-800-228-9100**.
2. **Click.** Visit our Customer Center on our website at **PhysiciansMutual.com**.

Policyowner's Information

Policyowner's Name _____

Address _____
Street

City _____ State _____ ZIP _____

Check here if this is a new address Phone Number (_____) _____

Email Address _____
(for service and product updates from us)

Policy Number _____ Requested Withdrawal Date (1st – 28th) _____
Date of Month

Policy Number _____ Requested Withdrawal Date (1st – 28th) _____
Date of Month

Authorization to Withdraw Funds

By Physicians Mutual Insurance Company and Physicians Life Insurance Company

I authorize the Company to initiate electronic debit entries to my account. I agree the Company's rights regarding each withdrawal will be the same as if I personally withdrew the funds. The withdrawals made by this method may be stopped by me with thirty (30) days written notice and is to remain in effect until you receive notice from me to revoke it. I understand this authorization can be discontinued immediately for any reason by the Company and will be discontinued if my account is closed or if there are insufficient funds on the scheduled date of the withdrawal.

X _____
Bank Account Owner's Signature Date

Attach a
voided check or
savings deposit
slip here ➤

John S. Policyowner
123 Any Street
Any Town, USA 12345

90-324
39001

1902

PAY TO THE ORDER OF _____

_____ \$ _____

MEMO _____ SIGNATURE _____

⑆ 2560064 ⑆ 9⑆

Routing No.

⑆ 03020032178⑆

Account No.

⑆ 902⑆

Check No.