Principal Life Insurance Company
Member of Principal Financial Group®
P.O. Box 14455
Des Moines, IA 50306-3455
Email: diservice@principal.com

Payment Authorization for Electronic Fund Transfers – Disability Insurance

This form must be completed and signed in order to draw premium payments. If there are not sufficient funds available at time of initial draw, Conditional Receipt would be invalid, and funds would be collected at time of Policy delivery.

Policy Information

Policy Number / Billing Account Number:	Policyowner Name:
Premium Payor Name *(if different than Policyowner)*:	

Request for *(choose one):*	Payment Frequency *(choose one)*:
☐ Setup EFT for a new Policy/Billing Account	☐ Monthly
☐ Make changes to EFT for an existing Policy/Billing Account	☐ Quarterly
	☐ Semi-Annual
	☐ Annual

Select all that apply *(choose at least one):*

☐ **Draft initial payment upon receipt of application (Enter amount to draft: $_____):** I authorize an immediate draft for the initial payment. Any premium shortage could also be drafted upon approval.

☐ **Draft premium payment upon Policy receipt:** I authorize a draft for the initial payment as indicated by the selected payment frequency above after I've signed Policy documents and the signed documents are received by Principal®.

☐ **Recurring Automatic EFT Payment:** I authorize payments to be drawn on a recurring basis as indicated by the selected payment frequency above. Note: Billing notices will be mailed for Quarterly, Semi-Annual or Annual payment frequencies, a billing notice is not mailed for monthly.

Financial Institution Information

Account Ownership *(choose one)*	**Account Type *(choose one)***
☐ Business Account	☐ Checking Account
☐ Personal Account	☐ Savings Account
Financial Institution Name	
Account Holder's Name	Account Holder's Email Address
Joint Account Holder's Name *(if applicable)*	Account Number
Financial Institution Routing Number *(must include all 9 digits, including leading zeros)*	

Authorization

I authorize the financial institution to honor withdrawals and/or electronic fund transfers by the Company listed above. The draft request to the financial institution must be honored on first presentment. I understand if the withdrawal requests are dishonored by the Company, whether with or without cause, that the Company shall be under no liability. This authorization will be in effect until cancelled either by myself, the Company or the financial institution. Any applicable refunds will be refunded back to the policy owner regardless of who the payee is.

X _____	_____	_____
Signature of Account Holder	Account Holder's Name (Printed)	Date (MM/DD/YYYY)
X _____	_____	_____
Signature of Joint Account Holder	Joint Account Holder's Name (Printed)	Date (MM/DD/YYYY)