

**UNITED OF OMAHA LIFE INSURANCE COMPANY  
COMPANION LIFE INSURANCE COMPANY**

MUTUAL OF OMAHA RETIREMENT SERVICES



# ELECTRONIC FUNDS TRANSFER AGREEMENT

## Plan Information

Contract No: \_\_\_\_\_ Cert No: \_\_\_\_\_

## Instructions for Completing This Form

- If the signature is missing from this form, this form is invalid.
- If mistakes are made, please cross a line through the item. Initial and date.
- Contact our customer Service Representative: Toll-Free- (800) 843-2455 Fax No.: (402) 997-1900
- Please return this form to: 10-Retirement Plans Division Mutual of Omaha Plaza Omaha, NE 68175

## Direct Deposit of Benefit Payments

### I understand and agree to the following:

- By completing this form, I authorize The Company (The Company) to directly deposit into my bank account via Electronic Funds Transfer (EFT) payment(s) due me under a contract issued by The Company to my bank. The information provided below, for credit to my account. Furthermore, I authorize and direct the bank to charge said account or the account of my estate for any payment made subsequent to my death or made in error and to refund any such payment to The Company upon its written request to the bank.
- I am responsible to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that The Company can rely on this information and will have no obligation to ensure the correctness of the information.
- Any payment(s) made into an incorrect bank account pursuant to the information reported on this form, will be forfeited by me and that The Company has no obligation to retrieve those funds or make replacement payment(s) to me.
- For myself, my heirs, executors and estate to indemnify and hold the bank and The Company harmless from any and all loss or damage of any nature whatsoever, including costs or attorneys fees earned by reason of said bank having entered into this agreement.
- The Company is not responsible for any bank charges or other costs associated with or arising out of this agreement.
- If my bank is not EFT capable checks will be mailed to my bank.
- I reserve the right to revoke and cancel this authorization. Such revocation and cancellation will take effect upon written notice received at The Company and the bank.

## Payee\Bank Information (United States Banks Only) – (Please Print)

Payee Information		Bank Information	
Full Name:		Bank Name:	
Street Address:		Street Address:	
City, State and Zip:		City, State and ZIP:	
Social Security No.: Ex. (999-99-9999)		Account No.:	
Phone No.: Ex. (999) 999-9999		Bank ABA Routing No.:	
E-mail Address:		Phone No.: Ex. (999) 999-9999	
		Please Select One:	<input type="checkbox"/> Checking <input type="checkbox"/> Saving
		Joint Account:	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Signature Information – (Please Print and Sign)

<u> X </u> Payee's Name	<u> X </u> Payee's Signature	_____ (Date)
<u> X </u> Joint Depositor's Name	<u> X </u> Joint Depositor's Signature	_____ (Date)

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