



American General Life Insurance Company (AGL)
The United States Life Insurance Company in the City of New York (USL)

Mailing Instructions
Send form(s) to:

Standard Address
PO Box 818005
Cleveland, OH 44181
Fax: 855-601-1834

Variable Life Service Center
PO Box 818016
Cleveland, OH 44181
Fax: 844-430-2639

In this form, the "Company" refers to the insurance company whose name is above. The Company shown above is solely responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Change Request to Bank Draft Authorization

Company Code	Policy Number	Name of Insured/Annuitant	Premium/Contribution Amount	Loan Repayment Amount (\$10 minimum)	Loan Repayment Frequency Select M-Q-SA-A

Note: Please provide all policy numbers pertaining to this request.

Request Type

- ☐ Add/Change Bank Details
☐ Discontinue Bank Draft (*select one below*)
☐ Change to Direct Bill (*default if nothing else selected*)
☐ Inactivate ABC (*Lapse Policies*)
☐ Discontinue ABC Loan Repayment

If you are changing the premium billing to direct, please select a mode below (*select only one*)

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

*Monthly direct billing is available via email.
Login to www.corebridgefinancial.com/lifeportal to enroll in Paperless billing and receive your bills via email

Draft Details (*Please provide the requested details*)

Payment information for recurring payments (*Complete both Payment Frequency and Payment Date*)

1. Payment Frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

2. Payment Date (*select only one option, if blank we'll default to the premium due date*)

- ☐ Premium Due Date (*the date the policy was issued, i.e. issued Jan. 4th would draft on the 4th*) - OR-
☐ Preferred Date (*Input the day payments will be drafted based on your payment frequency, 1st through the 28th*) _____

Past Due Premium Payments

If premiums are past due and you do not check this box, Bank Draft Authorization may not be established.

- ☐ Initiate debits against the account below for all outstanding premiums due.

Note: If policy is a lapsed Universal Life policy, the amount that will be drafted may be more than a multiple of the Planned Periodic Payment (PPP).

- ☐ Submit premium past-due via check \$ _____

Past Due Premium Payments (continued)

Bank Account Information: ☐ **Checking Account** ☐ **Savings Account** *Note: The default will be Checking if a selection is not made*
Voided Check Highly Recommended.

Bank Account Routing/Transit # _____ Bank Name _____

Bank Account Number _____ **Do not use debit/credit card.**

Bank Account Owner Name(s) _____
(The bank account owner name must match what is on the file at the bank. For business accounts, list Business, Authorized Signer, and use Business TAX ID).

Bank Acct. Owner No.1 SS#/If Business Acct, No. 1 Tax ID _____

Bank Acct. Owner No.1 Date of Birth (mm/dd/yyyy) _____

Bank Acct. Owner No.2 SS#/If Business Acct, No. 2 Tax ID _____

Bank Acct. Owner No.2 Date of Birth (mm/dd/yyyy) _____

Bank Account Owner Full Address (The bank account owner address must match what is on the file at the bank. For business accounts, list the address on file at the bank.)

Street _____ City _____ State _____ Zip _____

Phone _____ Email _____

AGREEMENT: I (we) authorize the Company, subject to my elections above, to initiate with the Financial Institution indicated by me (us) debit entries to the provided checking/savings account for any full or partial balance due for initial and/or subsequent premiums, as provided by this form. This authority is to remain in effect until the Company or Financial Institution has received **written notification of termination of the ABC account, from me (or either of us), at least 30 days prior to the collection date**, or until the ABC account otherwise terminates. It is agreed that:

1. No liability shall be incurred by the Company or other issuing company of the policy by reason of the dishonor of such debit entries.
2. Any notice of premiums due shall be waived and the bank account draft shall serve as a receipt. Credit will not be applied until draft payment is received by the Company. The ABC account authorization shall in no way alter or amend the provisions of the policy(ies). Request by me (us) to change the draft date does not alter the due date, and the Company will not waive or modify such due date for the grace period.
3. I (we) understand that no insurance applied for (except coverage pursuant to the terms of a separately-provided conditional receipt, if any) will become effective unless the Company issues a policy, the first premium is paid, and any other terms and conditions of the policy are met.
4. In the event I (we) later elect to cancel this authorization or if the Company determines I (we) am no longer eligible for ABC, I (we) acknowledge that the premium shall be payable in the amount and manner as provided in the policy.
5. This ABC account authorization shall continue in effect and premiums will continue to be debited, in accordance with this agreement unless or until terminated by the Company or by me (us), **by written notice to the other party at least 30 days prior to the collection date**. In addition, the Company may terminate the ABC account immediately if any charges are not paid upon presentation.
6. I understand and agree that any policy premium refund will be paid to the owner(s) of the policy unless otherwise provided by the policy
7. I understand and agree that a debit may be drawn from the above account for any premium(s) due on the above policy(ies) and American General Life Insurance Company will not be responsible for any change charges/fees related to this transaction.
8. I (we) authorize the Company to obtain information and/or reports from a consumer reporting agency or other company(ies) in order to verify, validate and/or authenticate the information and answers presented on this form.

Bank Account Owner Signature _____ **Date** _____

If Joint Account

Bank Account Owner Signature _____ **Date** _____