

**CREDIT UNION AUTHORIZATION FOR  
SHARE DEDUCTIONS OR OPEN END CREDIT**

Account No. \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_  
Last First Middle

I hereby authorize the \_\_\_\_\_ Credit Union to deduct from my shares or add to my open end credit account the required premium as stipulated in the contract(s) for my participation in the Insurance Program underwritten by Transamerica Assurance Company. This is to continue unless I notify the Credit Union in writing that same has been cancelled. The Credit Union shall have no liability except to remit premiums from funds I will make available in my share or open end credit account while such insurance program is in force.

\_\_\_\_\_ X \_\_\_\_\_  
Witness Signature

**AUTOMATIC PAYMENT AUTHORIZATION FOR CHARGES INITIATED BY**

TRANSAMERICA ASSURANCE COMPANY, Administrative Office, Little Rock, AR

Name of Bank Depositor \_\_\_\_\_  
(Print name as shown on Bank Records)

To \_\_\_\_\_, \_\_\_\_\_  
(Name of Financial Institution and branch, if any) (Transit No.)

\_\_\_\_\_  
(Address of Bank or Branch where account is maintained)

As a convenience to me, I request and authorize the Company to obtain payment of accounts becoming due the Company by initiating charges to my account in the form of checks, share drafts or electronic debit entries, and I request and authorize the financial institution named above to accept and honor the same and to charge the same to my account. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect not to receive notice if such entry is equal to the amount due the Company. This Authorization will remain in effect until I notify the Company or the financial institution in writing to terminate and the Company or the financial institution has a reasonable time to act on the termination. I hereby terminate any prior Authorization of the Company to initiate charges to this account, effective the date on which the initial charge in initiated by the Company under this Authorization. I understand that I may stop any charge by notifying the financial institution before my account is charged, and I may have the amount of the erroneous electronic debit entry credited to my account within 15 days after issuance of my statement or 45 days after posting, whichever occurs first.

\_\_\_\_\_ X \_\_\_\_\_  
(Date) (Signature of Bank Depositor)  
Bank Account No. of Depositor \_\_\_\_\_

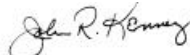
To: The Bank named above

So that you may comply with your depositor's request this Company agrees:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment (under this plan), including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of insurance or other right.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan of payment collection.

Administrative Office  
1020 West 4th Street  
Little Rock, Arkansas 72201

TRANSAMERICA ASSURANCE COMPANY



**RECEIPT**

Received from \_\_\_\_\_ (applicant) on application for  Individual  Single Parent Family  Family  Two-Adult Family Coverage;  Cancer Policy  Heart Policy  Accident Policy  Hospital Indemnity Policy  Intensive Care Policy with Transamerica Assurance Company \$ \_\_\_\_\_ for the initial premium covering \_\_\_\_\_ months. Coverage is effective on the date of application or \_\_\_\_\_, if the full first premium is paid, provided all persons proposed for insurance are acceptable in every respect under the Company's standard rate of premium and practices for the amount and plan of insurance applied for.

Date \_\_\_\_\_ Your premium is \_\_\_\_\_

\_\_\_\_\_ Payable  Monthly  Quarterly  Semi-Annual  Annual

Licensed Representative

Please notify the company if you do not receive a policy (or explanation) within 30 days.

TRANSAMERICA ASSURANCE COMPANY  
ADMINISTRATIVE OFFICE: 1020 WEST 4<sup>TH</sup> STREET, LITTLE ROCK, ARKANSAS 72201