Physicians Mutual® Insurance for all of us.®

2600 Dodge Street
Omaha, NE 68131-2671
Home Office: 402.633.1000
Customer Service 800.228.9100

Automatic Payment Authorization

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, Inc. 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

