DEBIT AUTHORIZATION

Please fill out and return with a ***voided check*** from your checkbook or *withdraw slip* from your savings account.

I authorize ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC. and the Financial Institution listed below to initiate electronic withdrawal from Checking Account __ or Savings Account __ (please check one) for monthly premiums on policy #_____("Policy"), dated _____issued by ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC. to _____ the undersigned Company ("Company"). This authority will remain in effect until canceled in writing or until the termination or expiration of the policy referenced above, whichever comes first.

The monthly withdrawal amount will be communicated to Company in accordance with the Policy.

The authorization is to remain in full force and effect until ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC., has received written notification from Company of its termination in such time and in such manner as to afford ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC., and its Bank or other depository, a reasonable opportunity to act upon such termination.

All notices and communications to Company will be to the following address, telephone number and email:

_____

_____

_____

_____	_____
Company Name	Financial Institution
_____	_____
Name (Please Print)	City/State
_____	_____
Authorized Signature	Account Number
_____	_____
Date	Routing and Transit Number

Initials_____

On behalf of Company, I understand that ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC., may initiate a reversal of any entry made under this agreement if an error has been made. I understand that the financial institution at which I have the above account is required to provide to me the procedures for resolving errors on entries made under this Debt Authorization agreement. I understand that ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC., will provide a written notice to me of the error within 24 hours.