AURORA
AN RGA COMPANY

PREMIUM BILLING MODE ELECTION

Aurora National Life Assurance Company, NAIC 61182, PO Box 4336, Clinton, IA 52733-4336
Telephone (800) 265-2652

NAME OF INSURED	POLICY NUMBER C
NAME OF POLICY OWNER(S)	POLICYOWNER'S DAYTIME PHONE NUMBER ( ) —

PREMIUM MODE ELECTION

The policy Owner requests the premium billing mode of the policy listed above to be changed to the mode as indicated below. All modes, other than annual, are subject to an additional charge and Company minimums.

☐ Annual ☐ Semi-Annual *(min. $300)* ☐ Quarterly *(min. $200)* ☐ Monthly *(min. $500)* ☐ Monthly by Electronic Funds Transfer (EFT)* *(min. $25)*

Important Note: If you elected the "Monthly by EFT" option above, the Electronic Funds Transfer section on page 2 of this form must also be completed and signed in addition to the "Declaration and Signature(s)" section below.

☐ *CHANGE OF ADDRESS FOR POLICY CORRESPONDENCE (If applicable)*

The policy Owner requests that all correspondence related to the policy listed above be sent to the following address:

TO THE ATTENTION OF

STREET ADDRESS

STREET ADDRESS

CITY | STATE | ZIP CODE + 4 —

If this address change affects Aurora policies other than the one listed above, please list the policy numbers below:

C	C
C	C

DECLARATION AND SIGNATURE(S)

The undersigned accepts the conditions stated above and hereby requests Aurora National Life Assurance Company to process the policy transaction indicated.

SIGNED AT (City, State)	DATE
SIGNATURE OF POLICY OWNER(S)	

CONTINUED ON NEXT PAGE
(Submit ALL pages of this form)

ELECTRONIC FUNDS TRANSFER (Required if "Monthly EFT" option is elected)

As a convenience to me (us), I (we) hereby request and authorize Aurora National Life Assurance Company ("Company") each month to effect payment of the premium(s) then due for the policies listed below by EFT or draft from the bank account below.

Policy Information

Policy Number	Name of Insured	Current Premium Information	
		Due Date	Amount
			$
			$
			$
			$

Bank Information

PRINT NAME OF BANK DEPOSITOR AS SHOWN ON BANK RECORDS	CHECKING ACCOUNT NUMBER

NAME AND ADDRESS OF BANK

BANK PHONE NUMBER

( ) -

ATTACH SAMPLE VOIDED CHECK HERE
(Paper clip or staple)

(Electronic Funds Transfer Payment request will not be honored without a voided check.
No deposit slips will be accepted.)

DECLARATION AND SIGNATURE(S)

I (we) understand that I (we) will continue to receive premium billing notices from Aurora for payment until this EFT request becomes effective.

This authorization shall remain in effect until terminated by the Company or by the policy Owner, Depositor or Bank in writing received by the Company at least 10 days prior to the funds transfer date. I (we) agree that the Company shall be fully protected in effecting such payments. This authorization shall also apply to any future increases or decreases in premium(s). The Company may combine premiums payable in a month for the policies listed above into one transfer for such month.

This EFT or draft payment arrangement shall automatically terminate if two fund transfers are dishonored in any 12-month period. A premium transferred by EFT or draft will be considered paid when the Company's bank account is credited therefor, provided that it is not subsequently dishonored. I (we) understand that if any EFT or draft payment is dishonored by the Bank and any monthly premium due the Company is not paid within the time stipulated in the policy, the policy will terminate except as otherwise provided therein.

The undersigned accepts the conditions stated above and hereby requests Aurora National Life Assurance Company to process the policy transaction indicated.

SIGNED AT (City, State)	DATE
SIGNATURE OF POLICY OWNER(S)	SIGNATURE OF BANK DEPOSITOR IF OTHER THAN THE POLICY OWNER