



Date

Name
Address
Address

RE: Insured:
Cert Number:
Product: Critical Illness

POLICYOWNER’S REQUEST TO PORT COVERAGE

Your American Public Life Insurance Company (APL) plan offers a portability benefit. Portability is the option to take certain employee benefits with you should you retire or change employers.

If you would like to choose the portability option for your APL plan, please complete the request below, along with the Electronic Funds Transfer Authorization, and fax to 877-807-0911 or mail to:

APL Customer Service
P.O. Box 925
Jackson, MS 39205-0925

Please port the following coverage:

Policyowner Name _____
Address _____
City, State, Zip _____
Email Address _____
Product to Port _____
Certificate Number _____
Employer Name _____

Signature _____ Date _____

If you need assistance completing this form, please call Customer Service at 800-256-8606, opt. 4. Thank you for trusting APL with your insurance needs!



APL Customer Service
P.O. Box 925
Jackson, MS 39205-0925

Phone: 800-256-8606
Fax: 877-807-0911
www.ampublic.com

Electronic Funds Transfer

Authorization to honor checks or electronic transfer of funds drawn by and payable to American Public Life Insurance Company, Jackson, MS.

To: _____ (Bank)

Branch Name, If Any: _____

Bank Address: _____

Bank Address: _____

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks or electronic transfer of funds drawn by and payable to the order of American Public Life Insurance Company, Jackson, Mississippi, provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of American Public Life Insurance Company to sign such checks or electronic transfer of funds. I agree that your rights in respect to each check or electronic transfer of funds shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or electronic transfer of funds.

I further agree that if any such check or electronic transfer of funds be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account Holder Name: _____ (Please Print)

Account Holder Address: _____ Account Holder Ad

Bank Routing Number: _____

Account Holder Signature _____ Date _____