

5 Authorization for Automatic Withdrawal (AWP)

Section 1 - Transaction Requested

Establish New AWP Account

I authorize Sons of Norway to make an immediate electronic draw from the bank account listed below upon receipt of this form.

- One time payment
- Ongoing payment deducted monthly on the first or fifteenth

Add to Existing AWP

Name of bank account owner: _____

Address: _____ City: _____ State: _____ Zip: _____

Full name of bank: _____ Routing number: _____

Bank Account Number: _____ Checking or Savings

Section 2 - Agreements and Signature

General Authorization

I authorize Sons of Norway to:

- Make electronic deposits, withdrawals, and corrections to my bank account that comply with U.S. law.
- Act on this authorization until I revoke it by contacting Sons of Norway.
- Make administrative changes to this authorization such as date and amount changes, or adding or removing certificates for automatic payment.
- Act upon electronic deposit, withdrawal, and administrative instructions I provide.

Signature of bank account owner

Date

6 Secondary Addressee

For the purpose of notification of a past due premium payment and possible lapse in coverage.

I choose to: Not name a secondary addressee Name a secondary addressee

print name of secondary addressee (first, middle initial, last)

address city state zip (country if not usa)

7 Declarations By Proposed Insured

I represent that all statements and answers made in all parts of this application are full, complete and true to the best of my knowledge and belief. It is agreed that:

- 1. All such statements and answers shall be the basis for and a part of any certificate issued.
- 2. No representative can accept risks, make or change contracts, or waive Sons of Norway’s rights, or requirements.
- 3. No insurance shall take effect unless the proposed insured is alive when the certificate is delivered and the full premium is received in Sons of Norway Headquarters.
- 4. I understand that a reduced death benefit amount is payable during the first two years if death results from sickness or other natural causes.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement or claim or an application containing any false, incomplete, or missing information is guilty of a felony of the third degree.

X _____ Date signed _____
 Signature of proposed insured

X _____ Date signed _____
 Signature of applicant/owner (if other than proposed insured)

I certify that I asked each question on the application as printed, recorded the answers exactly as given, and witnessed the signing of the application. Also, I certify that the insurance application is not intended to replace or change any insurance except as indicated above.

X _____ Agent number _____ City and state where signed _____
 Witnessed by Agent (signature)

_____ Agent’s Florida license # _____
 Agent’s name (please print)