



Deduction Agreement
AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

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Mailing Address:
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163



No: _____
(Administrative Office Use Only)

Employer or Organization Information:

Name to Appear on Bill: _____ Tax ID#: _____

E-mail Address: _____

Phone # _____ FAX # _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Billing lists will be sent to the employer or organization directly. Note: Must have a minimum of 10 policies to be put on List Bill. If less than 10 policies we will bill you using our combined billing method of pay.

Please complete the following questions regarding payroll deduction and requested bill date. (Select **one** for each option.):

- 1. Franchise Payroll Deduction Date: 1st 15th 28th
- 2. Billing Mode: Monthly Quarterly Semi-Annual Annual

Until further notice, the employer or organization agrees to honor the written request of its employees, members, or depositors for deduction from their accounts, salaries, or wages of monthly premiums on policies issued by the American National Life Insurance Company of New York (hereinafter called the Company) and to forward such deductions to the Company.

The employer or organization agrees to make deductions according to the schedule established with the Company and to remit all deductions to the Company or its designated agent on the due date.

The employer or organization assumes no other liability under this agreement, and this agreement will continue in force until 30 days after the Company receives written notice of termination from the employer or organization, together with payment of all deductions up to the date of termination. After that date, the employer or organization will have no further responsibility for deductions and each employee, member, or depositor will be responsible for making arrangements with the Company for payments. The employer or organization will not make further deductions for any employee, member, or depositor after that person terminates his or her relationship with the employer or organization.

The employer or organization will accept authorization cards signed by the employee, member, or depositor as complete authorization for deductions to be made, and no further notice or authorization will be required from either the employee, member, or depositor or the Company.

Franchise Representative Signature: _____ Date: Month/Day/Year

x _____
Franchise Representative – Print Name:

Soliciting Agent Signature: _____ Date: Month/Day/Year

x _____
Soliciting Agent – Print Name:

Branch Office, PSO Code: _____