



2588

GLOBE DEPOSIT FUND TRANSACTION FORM

For your protection, all transactions MUST be made in writing. PLEASE PRINT BLOCK LETTERS IN ALL CAPS IN BLUE OR BLACK INK. To request additional DEPOSIT FUND RIDER TRANSACTION FORMS, please write to: **Globe Life and Accident Insurance Company, Attn: Policy Services Dept., P.O. Box 8080, McKinney, TX, 75070**, or call **972-529-5085** Monday through Friday, 7:30 am - 4:30 pm CST.

Complete this section with every transaction.

HOME OFFICE USE ONLY

Policyholder's First Name:

Last Name: M.I.

Residence Address Street or Route:

City: State:

Zip Code: Home Phone No.: - -

Social Security Number: - - Policy Number:

E-mail Address

Withdrawal **Deposit** Please fill in the bubble completely for the transaction type selected

TOTAL AMOUNT:

\$, .

If you are making a withdrawal, a check will be drafted and sent to the policyholder's address in 7-10 days. A canceled check will be receipt of deposit. **Mail to: Globe Life and Accident Insurance Company, Attn: Policy Services Dept., P.O. Box 8080, McKinney, TX 75070**

Date Signed (mm-dd-yyyy)

- -

Signature of Authorized Person: _____

Change Automatic Deposit Amount Please fill in the bubble completely for the transaction type selected

CURRENT DEPOSIT FUND AMOUNT:

\$, .

NEW DEPOSIT FUND AMOUNT:

\$, .

Date Signed (mm-dd-yyyy)

- -

Signature of Policyholder: _____

Change Authorization for Deposit Account Withdrawal Please fill in the bubble completely for the transaction type selected

NOTE: Without this authorization no person other than the owner of a policy may withdraw funds on deposit with respect to a policy. This form requires the signature of the owner of the policy and the signature of the person authorized by the owner to act as his or her agent in withdrawing funds. This authority shall be effective until revoked by the owner by notice in writing to the Company and shall not be revoked by the disability of the owner. The owner will hold the Company harmless for payments made pursuant to this authorization after death or disability of the owner.

I hereby authorize the following person to act on my behalf in withdrawing funds from the Deposit Fund Rider of my policy.

Date Signed (mm-dd-yyyy)

- -

Signature of Policyholder: _____

Signature of Authorized Person: _____

Authorized Person's First Name:

Last Name: M.I.

Home Office Use Only
(Coder's Initials)