

DIRECT DEPOSIT AUTHORIZATION

POLICY NUMBER _____

INSTRUCTIONS - To request a change in payment direction, please complete the information below.

- Section I Complete in full.
- Section II Complete **only** if we do not have your **original notarized signature** on file.
- Section III Complete in full.
- Section IV Complete **only** if you are not able to attach a pre-printed voided check or if depositing funds into a savings account.

I. AUTHORIZATION SECTION

I / We hereby authorize the Company that provides the periodic payments (hereinafter called the "Company") to initiate deposits (credits) and/or corrections to the previous credits to the financial institution indicated. The financial institution is authorized to credit and/or correct the amounts to my/our account. This authority is to remain in full force and effect until the Company has received written notification from me/us of its termination in such time and in such manner as to afford the Company and financial institution a reasonable time to act on it.

If we do not have your original notarized signature on file, this request **must** be notarized in Section II.

Payee Signature Date

Joint Payee Signature (if applicable) Date

Payee Social Security Number

Joint Payee Social Security Number (if applicable)

Payee Resident – Street Address

Payee Resident – City, State, Zip

Payee Telephone Number

II. NOTARIZATION

Please have a notary complete the following information if your notarized signature is not already on file with us.

State of County of

On (date)

Before me (name of notary)

Personally appeared (name of Payee)

Personally appeared (name of Joint Payee)

Personally known to me - OR - proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is / are subscribed to the within instrument and acknowledge to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature.

WITNESS my hand and official seal.

Signature of Notary

III. ACCOUNT VERIFICATION

The name of the account must be the same as the designated payee. If, for example, payments are to be made to a guardian for the benefit of a minor, the account **must** be setup as a guardianship account for the benefit of the minor.

As a payee, I/we request that my/our payment(s) be directly deposited into my/our following account (check one).

Checking Account

A pre-printed voided check is to be attached to this form to complete your request.

If a pre-printed voided check is not available, Section IV is also required to be completed.

Savings Account

Section IV is also required to be completed.

Financial Institution Name

Names(s) Listed on Account

Account Number

ABA/Transit Number

Financial Institution - Street Address

Financial Institution - City, State, Zip

Financial Institution – Phone Number

IV. FINANCIAL INSTITUTION ACCT VERIFICATION

Without this verification, we are unable to complete your request and this form will be returned to you.

Signature of Financial Institution Representative

Title

Mailing Address

AEGON Structured Settlements
Administrative Offices
P.O. Box 35547
Louisville, KY 40232

Phone: 1.800.866.0002

Overnight Address

AEGON Structured Settlements
Administrative Offices
400 West Market Street
Louisville, KY 40202

Fax: 502.560.4860

MONUMENTAL LIFE INSURANCE COMPANY
TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY
TRANSAMERICA LIFE INSURANCE COMPANY
TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY
Member of the AEGON Group

www.aegonstructuredsettlements.com