

# DIRECT DEPOSIT AUTHORIZATION

MONUMENTAL LIFE INSURANCE COMPANY  
TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY  
TRANSAMERICA LIFE INSURANCE COMPANY

**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 \_\_\_\_\_

Name(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  
4333 Edgewood Road NE  
Cedar Rapids, IA 52406-3183  
Fax: 888.560.4860