AFGE Benefits Guide/Enrollment eApp

(Check off the plans you want to elect-Make changes at any time)

First Name *Last Name* *DOB* *Gender* *DL#/State* ______________

______ ______ ______ ______ *SSN#* ______________ *Birth Place* ____

*Address*______________ *Height*________ *Weight* ______ *Tobacco: If yes, what do you use*__________

*City/State/Zip*______________ *Cell Phone#*______________ *Date of Hire*______ *Marital Status*________

*Employer*______________ *Job Title*______________ *Annual Income*__________

Beneficiary Name *DOB* *Relationship to you*

______ ______ ______

Family Name(s) *DOB* *M/F*

1)______________
2)______________
3)______________
4)______________
5)______________

Physician's Name ______________
*Address/City*______________
Last doctors Visit ______________ *Surgeries last 5 yrs Y/N*

Medications *Reason* *Dosage* *Started*

1)______________
2)______________
3)______________
4)______________

1. *Union Life Plan to Replace FEGLI Opt B. Circle selection, Permanent plan, price locked in, cash value, goes into retirement. Term rates are approx. 1/2 the rate shown. All prices Bi-Weekly. 50k-2M Benefit, Juvenile policies avail for kids.*

Age at Issue (Ages 0-85 available)

Benefit	30-35	40-45	50-55	55-60
100k	$20	$35	$58	$73
150k	$29	$45	$85	$105
200k	$38	$59	$113	$137
250k	$46	$80	$140	$164
500k	$89	$160	$263	$328

2. Humana/ Cigna Dental & Vision: Dependents covered up to age 26. You can cover parents too!

Dental: *Plan 1-Cigna HMO In Network Only:*

$8 Employee $13 Employee+1
$18 Family

Plan 2-Cigna HMO High Option INO:

$18 Employee $31 Employee +1
$49 Family

Plan 3- Humana PPO:

$14 Employee $26 Employee+1
$39 Family

Plan 4 -Humana PPO:

$22 Employee $38 Employee+1

$56 Family

Vision: Humana/Cigna Circle one:

$5 Employee, $10 Emp+1, $14 Family

3. Aflac Disability Options: Choose up to 60% of gross salary (6K/month max benefit) Premiums locked in. Tax free benefits paid on top of paid or unpaid leave.

**$1000 month..0/7/6....$22 biweekly or $29(issue at age 50+)*
**$1500 month..0/7/6....$33 biweekly or $42(issue at age 50+)*
**$2000 month..0/7/6....$43 biweekly or $56(issue at age 50+)*
**$2500 month..0/7/6....$54 biweekly or $69(issue at age 50+)*
**$3000 month..0/7/6....$64 biweekly or $83(issue at age 50+)*

4. Aflac Accident/Hospital/Critical Illness: Circle selection, biweekly prices, premiums (5-30) are locked in, kids are included to age 26, $1 Aflac fee added biweekly.

	Accident	Hospital	Critical Illness (15K)
Employee	9.43	15.24	6.57 (age 30-39)
Emp + S	14.13	29.94	6.57+3.44 (age 30-39)
Emp + K	16.37	25.24	6.57 (age 30-39)
Family	21.07	39.95	6.57+3.44 (age 30-39)

My signature below authorizes the electronic submission of the Guaranteed Issue Group insurance plans. Full underwritten insurance might require additional information and the agent will contact me before submitting that application. Products may include an administrative fee as part of the premium.

Sign______________ **Date**________ **Email**______________

Return to Local Member Benefit Specialists: Jeff Roberts: Cell (870)261-3625 Email: jroberts@benefitarchitects.com
Risa Roberts Cell (573)286-1125 Email: rroberts@benefitarchitects.com

ANNUITIES & LIFE

HIPAA Authorization for the Release of Medical Information

INSURER: Fidelity & Guaranty Life Insurance Company

Name of Proposed/Existing Insured (please print or type):	Date of Birth:

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, pharmacy, pharmacy benefit manager or other health care provider that has provided payment, treatment or services to Patient or on Patient's behalf within the past 10 years ("Providers") to disclose my entire medical record, medications prescribed and any other protected health information concerning Patient to Fidelity & Guaranty Life. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict Patient's protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, medical facility, pharmacy, pharmacy benefit manager or other health care provider to release and disclose my entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that Fidelity & Guaranty Life may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Fidelity & Guaranty Life.

This release is valid for the lesser of 24 months or the closing of the claim following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Fidelity & Guaranty Life Insurance Company, 801 Grand Ave., Suite 2600, Des Moines, IA 50309. I understand that a revocation is not effective to the extent that any of Providers has already relied on this Authorization to disclose information about me or to the extent that Fidelity & Guaranty Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by Fidelity & Guaranty Life except as authorized by me or as required by law.

I understand that Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical records, Fidelity & Guaranty Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Release all medical records to our authorized representative for Fidelity & Guaranty Life Insurance Company.

Signature of Proposed Insured or Authorized Representative:	Date:

AFGE Member Sample Bi-Weekly Rates

Available to all AFGE Members

Representative: Risa & Jeff Roberts	Cell:
	Email:

Note: Rates & Statements are for 2019 Enrollment Only. Rates Subject to Change Prior to Enrollment

Accident - 24-Hr On & Off-the-Job Coverage	Individual Member	Member & Spouse	Member and Kids	Family
	9.43 Bi-Weekly	14.13 Bi-Weekly	16.37 Bi-Weekly	21.07 Bi-Weekly

Plan includes $50 Annual Wellness after 12-Months Active, per Covered Person • Pays a Max $125 for initial X-Ray or Doctor Services for accidents, if treated within 72-Hours. Pays$1,000 for 1st-24 Hour Day in Hospital, then $200 a day, up to 365 days ($400 per day, Intensive Care for up to 30-Days) • Major Fracture Injuries (Chip Fractures pays 25%): Hip/Thigh$4,000, Vertebrae (except Processes) $3,600, Leg $2,400, Forearm/Hand/Wrist $2,000, Foot/Ankle/Kneecap $2,000, Shoulder Blade/Collar Bone $1,600, Lower Jaw (mandible) $1,600, Skull (simple) $1,400, Upper Arm/Upper Jaw $1,400, Facial Bones (except teeth) $1,200, Vertebral Processes $800, Coccyx/Rib/Finger/Toe $320. Must provide proof of Treatment/ Services, a Doctor/Hospital Bill/Receipt. • Pays Accidental Death for Employee **$50,000**, Spouse $25,000, Dependents at $5,000

Hospital Indemnity	Individual Member	Member & Spouse	Member and Kids	Family
	15.24 Bi-Weekly	29.94 Bi-Weekly	25.24 Bi-Weekly	39.95 Bi-Weekly

When due to a covered accidental injury or sickness: Plan includes Hospital Admission Benefit of $1,000 per confinement, once per covered sickness or accident per calendar year. Excludes ER. See plan for details. • Outpatient Doctor's Office Visit – max of 6 visits per calendar year - $25 each visit. Chiropractor Visit – max of 4 visits per calendar year - $20 each visit. Major Diagnostic Exam – CT/CAT scan, MRI, EEG - $150 payment. Hospital ER Visit – max of 5 visits per calendar year - $100 per day. Inpatient Surgery and Anesthesia - $500. Outpatient Surgery and Anesthesia - $250.

Group Critical Illness

Guaranteed Issue:

Heart • Stroke • Cancer

$50 Wellness Annually per Adult

Pays 100% of Benefit for Diagnosis of:

- Heart Attack
- Stroke
- Cancer Internal or Invasive
- Major Organ Transplant
- Kidney Failure
- Bone Marrow Transplant
- Sudden Cardiac Arrest
- Severe Burns
- Paralysis
- Coma
- Loss of Speech
- Sight
- Hearing

Pays 25% of Benefit Amount for:

- Non-Invasive Cancer
- Coronary Artery Bi-Pass Surgery
- Pays$250 for Skin Cancer (1X per year)

Age Band	NON-SMOKER RATES Member Benefit	Member Premium	Max Spouse Benefit	Spouse Premium	SMOKER RATES Member Benefit	Member Premium	Max Spouse Benefit	Spouse Premium
(18-29)	$5,000	$2.00	$5,000	$1.87	$5,000	$2.56	$5,000	$2.43
	$10,000	$3.30	$5,000	$1.87	$10,000	$4.42	$5,000	$2.43
	$15,000	$4.60	$7,500	$2.45	$15,000	$6.29	$7,500	$3.29
	$20,000	$5.90	$10,000	$3.04	$20,000	$8.15	$10,000	$4.16
	$25,000	$7.20	$12,500	$3.62	$25,000	$10.01	$12,500	$5.02
	$30,000	$8.50	$15,000	$4.20	$30,000	$11.87	$15,000	$5.89
(30-39)	$5,000	$2.66	$5,000	$2.53	$5,000	$3.94	$5,000	$3.80
	$10,000	$4.62	$5,000	$2.53	$10,000	$7.17	$5,000	$3.80
	$15,000	$6.57	$7,500	$3.44	$15,000	$10.41	$7,500	$5.36
	$20,000	$8.53	$10,000	$4.35	$20,000	$13.65	$10,000	$6.91
	$25,000	$10.49	$12,500	$5.26	$25,000	$16.89	$12,500	$8.46
	$30,000	$12.45	$15,000	$6.18	$30,000	$20.12	$15,000	$10.01
(40-49)	$5,000	$4.71	$5,000	$4.58	$5,000	$7.47	$5,000	$7.33
	$10,000	$8.72	$5,000	$4.58	$10,000	$14.23	$5,000	$7.33
	$15,000	$12.74	$7,500	$6.52	$15,000	$21.00	$7,500	$10.65
	$20,000	$16.75	$10,000	$8.46	$20,000	$27.76	$10,000	$13.97
	$25,000	$20.76	$12,500	$10.40	$25,000	$34.53	$12,500	$17.28
	$30,000	$24.77	$15,000	$12.34	$30,000	$41.29	$15,000	$20.60
(50-59)	$5,000	$7.96	$5,000	$7.82	$5,000	$13.18	$5,000	$13.05
	$10,000	$15.21	$5,000	$7.82	$10,000	$25.67	$5,000	$13.05
	$15,000	$22.47	$7,500	$11.39	$15,000	$38.15	$7,500	$19.23
	$20,000	$29.73	$10,000	$14.95	$20,000	$50.64	$10,000	$25.40
	$25,000	$36.98	$12,500	$18.51	$25,000	$63.12	$12,500	$31.58
	$30,000	$44.24	$15,000	$22.07	$30,000	$75.61	$15,000	$37.75
(60+)	$5,000	$14.00	$5,000	$13.87	$5,000	$23.49	$5,000	$23.36
	$10,000	$27.37	$5,000	$13.87	$10,000	$46.28	$5,000	$23.36
	$15,000	$40.61	$7,500	$20.46	$15,000	$69.07	$7,500	$34.69
	$20,000	$53.91	$10,000	$27.04	$20,000	$91.86	$10,000	$46.02
	$25,000	$67.22	$12,500	$33.63	$25,000	$114.65	$12,500	$57.35
	$30,000	$80.52	$15,000	$40.21	$30,000	$137.45	$15,000	$68.67

Allstate Benefits quick reference rate guide

v. 2021.11.05

Non-Tobacco Users (bi-weekly rates)

Death Benefit	Age 30	Age 35	Age 40	Age 45	Age 50	Age 55	Age 60	Age 65
$ 10,000.00	$ 4.24	$ 4.74	$ 5.84	$ 6.78	$ 8.78	$ 10.62	$ 13.74	$ 18.70
$ 20,000.00	$ 7.42	$ 8.42	$ 10.62	$ 12.52	$ 16.50	$ 20.16	$ 26.46	$ 36.40
$ 30,000.00	$ 10.60	$ 12.12	$ 15.40	$ 18.24	$ 24.22	$ 29.72	$ 39.20	$ 54.10
$ 40,000.00	$ 13.78	$ 15.80	$ 20.16	$ 23.96	$ 31.94	$ 39.26	$ 51.92	$ 71.80
$ 50,000.00	$ 16.96	$ 19.48	$ 24.94	$ 29.68	$ 39.66	$ 48.82	$ 64.64	$ 89.50
$ 60,000.00	$ 20.14	$ 23.16	$ 29.72	$ 35.42	$ 47.38	$ 58.36	$ 77.38	$ 107.20
$ 70,000.00	$ 22.30	$ 26.84	$ 34.50	$ 41.14	$ 55.12	$ 67.92	$ 90.10	$ 124.90
$ 80,000.00	$ 26.48	$ 30.52	$ 39.28	$ 46.88	$ 62.84	$ 77.46	$ 102.82	$ 142.60
$ 90,000.00	$ 29.66	$ 34.22	$ 44.06	$ 52.60	$ 70.56	$ 87.02	$ 115.56	$ 160.30
$ 100,000.00	$ 32.84	$ 37.90	$ 48.84	$ 58.32	$ 78.28	$ 96.56	$ 128.28	$ 178.00
$ 110,000.00	$ 36.02	$ 41.58	$ 53.62	$ 64.06	$ 86.00	$ 106.12	$ 141.00	$ 195.70
$ 120,000.00	$ 39.20	$ 45.26	$ 58.38	$ 69.78	$ 93.72	$ 115.66	$ 153.74	$ 213.40
$ 130,000.00	$ 42.38	$ 48.94	$ 63.16	$ 75.50	$ 101.44	$ 125.22	$ 166.46	$ 231.10
$ 140,000.00	$ 45.56	$ 52.62	$ 67.94	$ 81.24	$ 109.16	$ 134.78	$ 179.18	$ 248.80
$ 150,000.00	$ 48.74	$ 56.32	$ 72.72	$ 86.96	$ 116.88	$ 144.34	$ 191.92	$ 266.50

Tobacco Users (bi-weekly rates)

Death Benefit	Age 30	Age 35	Age 40	Age 45	Age 50	Age 55	Age 60	Age 65
$ 10,000.00	$ 6.34	$ 7.44	$ 8.86	$ 10.94	$ 14.06	$ 18.48	$ 23.52	$ 32.80
$ 20,000.00	$ 11.60	$ 13.82	$ 16.66	$ 20.82	$ 27.06	$ 35.92	$ 46.02	$ 64.58
$ 30,000.00	$ 16.88	$ 20.20	$ 24.46	$ 30.70	$ 40.08	$ 53.34	$ 68.52	$ 96.38
$ 40,000.00	$ 22.14	$ 26.58	$ 32.26	$ 40.58	$ 53.08	$ 70.76	$ 91.02	$ 128.16
$ 50,000.00	$ 27.40	$ 32.96	$ 40.06	$ 50.44	$ 66.08	$ 88.18	$ 113.52	$ 159.96
$ 60,000.00	$ 32.68	$ 39.34	$ 47.88	$ 60.32	$ 79.08	$ 105.62	$ 136.04	$ 191.74
$ 70,000.00	$ 37.96	$ 45.72	$ 55.68	$ 70.20	$ 92.08	$ 123.04	$ 158.54	$ 223.54
$ 80,000.00	$ 43.22	$ 52.12	$ 63.48	$ 80.08	$ 105.10	$ 140.46	$ 181.04	$ 255.32
$ 90,000.00	$ 48.50	$ 58.48	$ 71.28	$ 89.96	$ 118.10	$ 157.90	$ 203.54	$ 287.10
$ 100,000.00	$ 53.76	$ 64.86	$ 79.08	$ 99.84	$ 131.10	$ 175.32	$ 226.04	$ 318.90
$ 110,000.00	$ 59.02	$ 71.24	$ 86.88	$ 109.72	$ 144.10	$ 192.74	$ 248.56	$ 350.68
$ 120,000.00	$ 64.30	$ 77.62	$ 94.68	$ 119.60	$ 157.10	$ 210.16	$ 271.06	$ 382.48
$ 130,000.00	$ 69.58	$ 84.02	$ 102.50	$ 129.48	$ 170.12	$ 227.60	$ 293.56	$ 414.26
$ 140,000.00	$ 74.84	$ 90.40	$ 110.30	$ 139.36	$ 183.12	$ 245.02	$ 316.06	$ 446.04
$ 150,000.00	$ 80.12	$ 96.78	$ 118.10	$ 149.24	$ 196.12	$ 262.46	$ 338.56	$ 477.84

Spouse Coverage - Non-Tobacco || Spouse is **only** eligible for >$10k **if** spouse is employed.

Death Benefit	Age 30	Age 35	Age 40	Age 45	Age 50	Age 55	Age 60	Age 65
$ 10,000.00	$ 4.24	$ 4.74	$ 5.84	$ 6.78	$ 8.78	$ 10.62	$ 13.74	$ 18.70
$ 20,000.00	$ 7.42	$ 8.42	$ 10.62	$ 12.52	$ 16.50	$ 20.16	$ 26.46	$ 36.40
$ 30,000.00	$ 10.60	$ 12.12	$ 15.40	$ 18.24	$ 24.22	$ 29.72	$ 39.20	$ 54.10

Spouse Coverage - Tobacco || Spouse is **only** eligible for >$10k **if** spouse is employed.

Death Benefit	Age 30	Age 35	Age 40	Age 45	Age 50	Age 55	Age 60	Age 65
$ 10,000.00	$ 6.34	$ 7.44	$ 8.86	$ 10.94	$ 14.06	$ 18.48	$ 23.52	$ 32.80
$ 20,000.00	$ 11.60	$ 13.82	$ 16.66	$ 20.82	$ 27.06	$ 35.92	$ 46.02	$ 64.58
$ 30,000.00	$ 16.88	$ 20.20	$ 24.46	$ 30.70	$ 40.08	$ 53.34	$ 68.52	$ 96.38

Allstate Benefits
Children's Term Rider for Group Universal Life (GUL23)
when the Payor Waiver of Premium Rider is included

Bi-weekly Add-on Cost

Children's Term Rider Benefit Amount	Add-On Cost for Employee issue age 18-55	Add-On Cost for Employee issue age 56-65
$2,000	$0.45	$0.42
$3,000	$0.68	$0.63
$4,000	$0.90	$0.84
$5,000	$1.13	$1.05
$6,000	$1.35	$1.26
$7,000	$1.58	$1.47
$8,000	$1.80	$1.68
$9,000	$2.03	$1.89
$10,000	$2.25	$2.10
$11,000	$2.48	$2.31
$12,000	$2.70	$2.52
$13,000	$2.93	$2.73
$14,000	$3.15	$2.94
$15,000	$3.38	$3.15
$16,000	$3.60	$3.36
$17,000	$3.83	$3.57
$18,000	$4.05	$3.78
$19,000	$4.28	$3.99
$20,000	$4.50	$4.20

THIS DOCUMENT IS FOR AGENT AND ENROLLER USE ONLY.

Note that a child may be covered by their own GUL23 certificate or by the children's term rider attached to the employee's certificate, but not both at the same time.

The Children's Term Rider only covers children ages 0-25 as of the effective date of coverage.

Rider premium (add-on cost) must be added to the GUL23 premium to get the total certificate premium.

Please process for the current pay period. Thank you!

Standard Form 1199A (EG)
(Rev. August 2012)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

Jeff Roberts (870) 261-3625 JRoberts@benefitarchitects.com

OMB No. 1510-0007

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT
SELF

C CLAIM OR PAYROLL ID NUMBER
SSN:

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☒ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*
- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☒ Other ALLOTMENT *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT
ALLOTMENT	

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
X	
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION
FROST BANK
PO BOX 1600
SAN ANTONIO, TX

ROUTING NUMBER: 1 1 4 0 0 0 0 9 — CHECK DIGIT: 3

DEPOSITOR ACCOUNT TITLE
RMJP- AFLAC

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE
Karen Green	Karen E. Green	800-733-7236	9-8-2016

Financial institutions should refer to the GREEN BOOK for further instructions.
THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224

GOVERNMENT AGENCY COPY

1199-207
Designed using Perform Pro, WHS/DIOR, Mar 97

Return to: Jeff Roberts Cell: (870) 261-3625 Email: JRoberts@benefitarchitects.com

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury
Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT
SELF

C CLAIM OR PAYROLL ID NUMBER
SSN:

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☒ SAVINGS

E DEPOSITOR ACCOUNT NUMBER
3330

F TYPE OF PAYMENT *(Check only one)*
- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☒ Other Savings Allotment *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
X	
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION
PNC Financial Services Group
101 W Washington Street, Suite 400E
Indianapolis IN 46255

ROUTING NUMBER: 0 4 1 0 0 0 1 2 CHECK DIGIT: 4

DEPOSITOR ACCOUNT TITLE
Fidelity & Guaranty Life Insurance Company

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER
Christine Wise	[signature]	317-267-7625

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224

GOVERNMENT AGENCY COPY

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