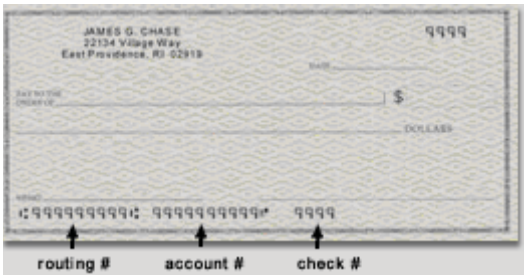
AUTOPAY
ENROLLMENT FORM

AMICA LIFE INSURANCE COMPANY
PO Box 6008
Providence, Rhode Island 02940-6008

PREAUTHORIZED PAYMENT AGREEMENT

I (We) hereby authorize Amica Life Insurance Company, hereafter called Amica Life, to initiate debit entries to my (our) bank account indicated below, and the Depository identified below hereafter called Depository, to debit the same such account. This authority is to remain in full force and effect until Amica Life has received notification from me (or either of us) of its termination in such time and in such a manner as to afford Amica Life and DEPOSITORY a reasonable opportunity to act on it.

Please provide your bank account information:



Policy Number(s): 1-000182271

Payment Frequency: ☐ MONTHLY ☐ ANNUAL

Bank Account Type (checking or savings):

Your Name on Bank Account:

Bank Routing Number:

Bank Account Number:

Day of the month on which to withdraw premiums:

(Please note, withdrawals for the 29th, 30th, or 31st of each month are not available)

Name(s): _____
(Please Print)

Date: _____

Signed: X _____ Signed: X _____