DIRECT DEPOSIT AUTHORIZATION

TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY
TRANSAMERICA LIFE INSURANCE COMPANY
TRANSAMERICA PREMIER 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 VERIFICATIO

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 and Overnight Address
AEGON Structured Settlements
Administrative Offices
4333 Edgewood Road NE
Cedar Rapids, IA 52499

Phone: 1.800.866.0002
Fax: 888.560.4860