



# SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM

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# TOP 5 OBJECTIVES

- ① Understand the Schedule of Social Security Benefit Payments
- ② Understand the 5 Deposit/Withdrawal Options
- ③ Review How to Accurately Complete the Social Security Benefit Billing Authorization Form
- ④ Understand Direct Express MasterCard and the Information Necessary for Successful Draft
- ⑤ Review 10-day Rule to Determine Deposit/Withdrawal Date for Client.



## AGENT BENEFITS

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### **Increased Persistency**

*Premiums withdrawn as soon as Social Security Benefits are paid. Timing our withdrawal with the deposit of the clients Social Security Benefits will ensure premiums are collected prior to clients withdrawing funds.*

### **Increased Sales Opportunities**

*We have the ability to withdraw on corresponding Social Security Benefit deposit dates for both checking accounts and the Direct Express MasterCard. We are one of few carriers that accept the Direct Express MasterCard as a mode of payment.*



## CLIENT BENEFITS

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### **Social Security Deposit Dates Matched**

*Clients can have the peace of mind knowing their premiums will be withdrawn as soon as their Social Security Benefits are deposited. We find that clients who rely on Social Security deposits to cover the cost of their life insurance policy want the coverage to stay active.*

### **Direct Express MasterCard Accepted**

*We have the ability to withdraw on corresponding Social Security Benefit deposit dates for both checking accounts and the Direct Express MasterCard. We are one of few carriers that accept the Direct Express MasterCard as a mode of payment.*

# Schedule Of Social Security Benefit Payments 2016



JANUARY 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

MARCH 2016						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY 2016						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 2016						
S	M	T	W	T	F	S
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5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2016						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER 2016						
S	M	T	W	T	F	S
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2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER 2016						
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13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER 2016						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Benefits paid on	Birth date on
Second Wednesday	1 <sup>st</sup> – 10 <sup>th</sup>
Third Wednesday	11 <sup>th</sup> – 20 <sup>th</sup>
Fourth Wednesday	21 <sup>st</sup> – 31 <sup>st</sup>

● Supplemental Security Income (SSI)  
   Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments

If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.

[www.socialsecurity.gov](http://www.socialsecurity.gov)

Social Security Administration  
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 ICN 456100  
 Unit of Issue - HD (one hundred)  
 January 2015 (Recycle prior editions)

Printed on recycled paper

Access the Schedule of Social Security Benefit Payments on your web portal



# Schedule Of Social Security Benefit Payments 2016



JANUARY 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

MARCH 2016						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL 2016						
S	M	T	W	T	F	S
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3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY 2016						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 2016						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY 2016						
S	M	T	W	T	F	S
				1	2	
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2016						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER 2016						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER 2016						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

DECEMBER 2016						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Benefits paid on	Birth date on
Second Wednesday	1 <sup>st</sup> – 10 <sup>th</sup>
Supplemental Security Income (SSI)	
Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments	

If you don't receive your payment on the expected date, contact Social Security three additional mailing days before contacting Social Security.

[www.socialsecurity.gov](http://www.socialsecurity.gov)

UNIT OF ISSUE - 11/1 (one unimarec)  
January 2015 (Recycle prior editions)  
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## Social Security Benefit Payments

- Benefits paid the 1<sup>st</sup> of the month.  
*Option A on Social Security Benefit Billing Authorization Form*
- Benefits paid the 3<sup>rd</sup> of the month.  
*Option B on Social Security Benefit Billing Authorization Form*
- Benefits established by payor birthdate.  
*Option C, D, or E on Social Security Benefit Billing Authorization Form*



## 10-DAY RULE

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The policy effective date **cannot** occur within 10 business days of the in-house date (date application is received by home office).

*Please note: For option A & B, the effective date will always be the 28<sup>th</sup> of the prior month and options C, D & E the effective date will match the deposit date.*

If the policy effective date occurs within 10 business days of the in-house date, the initial draft date would need to **move to the following month**. Initial draft month cannot exceed one benefit payment cycle past in-house date.

# Schedule Of Social Security Benefit Payments 2016



JANUARY 2016							FEBRUARY 2016							MARCH 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	6	7	8	9	10	11	12	13
3	4	5	6	7	8	9	7	8	9	10	11	12	13	13	14	15	16	17	18	19
10	11	12	13	14	15	16	14	15	16	17	18	19	20	20	21	22	23	24	25	26
17	18	19	20	21	22	23	21	22	23	24	25	26	27	27	28	29	30	31		
24	25	26	27	28	29	30	28	29												
31																				

APRIL 2016							MAY 2016							JUNE 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	7	5	6	7	8	9	10	11
3	4	5	6	7	8	9	8	9	10	11	12	13	14	12	13	14	15	16	17	18
10	11	12	13	14	15	16	15	16	17	18	19	20	21	19	20	21	22	23	24	25
17	18	19	20	21	22	23	22	23	24	25	26	27	28	26	27	28	29	30		
24	25	26	27	28	29	30	29	30	31											

JULY 2016							AUGUST 2016							SEPTEMBER 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	4	5	6	7	8	9	10	
3	4	5	6	7	8	9	7	8	9	10	11	12	13	11	12	13	14	15	16	17
10	11	12	13	14	15	16	14	15	16	17	18	19	20	18	19	20	21	22	23	24
17	18	19	20	21	22	23	21	22	23	24	25	26	27	25	26	27	28	29	30	
24	25	26	27	28	29	30	28	29	30	31										
31																				

OCTOBER 2016							NOVEMBER 2016							DECEMBER 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
						1	1	2	3	4	5	6	4	5	6	7	8	9	10	
2	3	4	5	6	7	8	6	7	8	9	10	11	12	11	12	13	14	15	16	17
9	10	11	12	13	14	15	13	14	15	16	17	18	19	18	19	20	21	22	23	24
16	17	18	19	20	21	22	20	21	22	23	24	25	26							

## 10-Day Rule Example

If the in-house date is January 18, 2016 and the client's Social Security benefits are deposited on the first of the month – February 1<sup>st</sup> 2016 would be the next deposit date. January 18th falls within 10 business days of January 28<sup>th</sup> effective date. The effective date would need to be pushed out to February 28<sup>th</sup> 2016.

The next draft date – March 1, 2016—would need to be selected.

JANUARY 2016							FEBRUARY 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	
3	4	5	6	7	8	9	7	8	9	10	11	12	13
10	11	12	13	14	15	16	14	15	16	17	18	19	20
17	18	19	20	21	22	23	21	22	23	24	25	26	27
24	25	26	27	28	29	30	28	29					
31													



Schedule Of Social Security Benefit Payments 2016



JANUARY 2016							FEBRUARY 2016							MARCH 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	6	7	8	9	10	11	12	13
3	4	5	6	7	8	9	7	8	9	10	11	12	13	13	14	15	16	17	18	19
10	11	12	13	14	15	16	14	15	16	17	18	19	20	20	21	22	23	24	25	26
17	18	19	20	21	22	23	21	22	23	24	25	26	27	27	28	29	30	31		
24	25	26	27	28	29	30	28	29												
31																				

APRIL 2016							MAY 2016							JUNE 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	7	5	6	7	8	9	10	11
3	4	5	6	7	8	9	8	9	10	11	12	13	14	12	13	14	15	16	17	18
10	11	12	13	14	15	16	15	16	17	18	19	20	21	19	20	21	22	23	24	25
17	18	19	20	21	22	23	22	23	24	25	26	27	28	26	27	28	29	30		
24	25	26	27	28	29	30	29	30	31											

JULY 2016							AUGUST 2016							SEPTEMBER 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	4	5	6	7	8	9	10	
3	4	5	6	7	8	9	7	8	9	10	11	12	13	11	12	13	14	15	16	17
10	11	12	13	14	15	16	14	15	16	17	18	19	20	18	19	20	21	22	23	24
17	18	19	20	21	22	23	21	22	23	24	25	26	27	25	26	27	28	29	30	
24	25	26	27	28	29	30	28	29	30	31										
31																				

OCTOBER 2016							NOVEMBER 2016							DECEMBER 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
						1								4	5	6	7	8	9	10
2	3	4	5	6	7	8	6	7	8	9	10	11	12	11	12	13	14	15	16	17
9	10	11	12	13	14	15	13	14	15	16	17	18	19	18	19	20	21	22	23	24
16	17	18	19	20	21	22	20	21	22	23	24	25	26	25	26	27	28	29	30	31

NOVEMBER 2016							DECEMBER 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S
		1	2	3	4	5					1	2	3
6	7	8	9	10	11	12	4	5	6	7	8	9	10
13	14	15	16	17	18	19	11	12	13	14	15	16	17
20	21	22	23	24	25	26	18	19	20	21	22	23	24
27	28	29	30				25	26	27	28	29	30	31

### 10-Day Rule Example

If the in-house date is November 3, 2016 and the client's Social Security benefits are deposited on the Second Wednesday of the month—November 9, 2016—this falls within 10 business days.

The next draft date—December 14, 2016—would need to be selected.

Access the Social Security Benefit Billing Authorization Form on your agent web portal.

This form is required if the client would like their premium withdrawal to match their Social Security Benefit deposit.

<input type="checkbox"/> Transamerica Financial Life Insurance Company 440 Mamaroneck Avenue, Harrison, NY 10528 <input type="checkbox"/> Transamerica Life Insurance Company <input type="checkbox"/> Transamerica Premier Life Insurance Company <input type="checkbox"/> Stonebridge Life Insurance Company Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499	<b>SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM</b>  POLICY NUMBER _____
<b>SOCIAL SECURITY BENEFIT PAYMENT PAID ON:</b> <b>Box A - Required</b> Please select only one box to indicate the DEPOSIT/WITHDRAWAL options: <input type="checkbox"/> Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A) <input type="checkbox"/> Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B) <input type="checkbox"/> Benefit paid on Second Wednesday (Option C) <input type="checkbox"/> Benefit paid on Third Wednesday (Option D) <input type="checkbox"/> Benefit paid on Fourth Wednesday (Option E)	
Initial Draft Month _____ (Cannot exceed one benefit payment cycle past application date)	
<b>INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)</b> <b>Box B - Bank Withdrawal Account</b> Insured Name: _____ Birthdate of Insured: _____ Payor Name if different than Insured: _____ Birthdate of Payor: _____ <input type="checkbox"/> Survivor Account Financial Institution Name, Office or Branch _____ Financial Institution Address City, State, Zip _____ List All Authorized Account Holders _____ Check One: <input type="checkbox"/> Checking <input type="checkbox"/> Savings \$ _____ Premium amount _____ Transit Routing Number _____ Account Number _____ Account Holder Signature _____	
<b>Box C - Direct Express MasterCard</b> Insured Name: _____ Birthdate of Insured: _____ Payor Name if different than Insured: _____ Birthdate of Payor: _____ 5332 48 _____ <input type="checkbox"/> Survivor Account Direct Express MasterCard Account Number _____ \$ _____ Premium amount _____ Cardholder Signature _____ Date _____ Card Expiration Date _____ Mo/Yr _____ Cardholder Name ( Please Print) _____	
<p>I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.</p> <p>As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.</p> <p>This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.</p>	
Signature of Authorized Account Holder _____ Date _____	
SSBA 0215	



# Social Security Benefit Billing Options

<b>SOCIAL SECURITY BENEFIT PAYMENT PAID ON:</b>	
<b>Box A - Required</b>	
Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:	
<input type="checkbox"/> Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)	<input type="checkbox"/> Benefit paid on Second Wednesday (Option C)
<input type="checkbox"/> Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)	<input type="checkbox"/> Benefit paid on Third Wednesday (Option D)
	<input type="checkbox"/> Benefit paid on Fourth Wednesday (Option E)
Initial Draft Month _____ (Cannot exceed one benefit payment cycle past application date)	
<b>INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)</b>	
<b>Box B - Bank Withdrawal Account</b>	
Insured Name: _____	Birthdate of Insured: _____
Payor Name if different than Insured: _____	Birthdate of Payor: _____
	<input type="checkbox"/> Survivor Account
Financial Institution Name, Office or Branch _____	Financial Institution Address City, State, Zip _____
	Check One: <input type="checkbox"/> Checking <input type="checkbox"/> Savings \$ _____
List All Authorized Account Holders _____	Premium amount _____
Transit Routing Number _____	Account Number _____
	Account Holder Signature _____
<b>Box C - Direct Express MasterCard</b>	
Insured Name: _____	Birthdate of Insured: _____
Payor Name if different than Insured: _____	Birthdate of Payor: _____
<b>5332 48</b> _____	<input type="checkbox"/> Survivor Account
Direct Express MasterCard Account Number _____	
Cardholder Signature _____	Date _____
	\$ _____ Premium amount
Card Expiration Date _____	Mo/Yr _____
	Cardholder Name ( Please Print) _____

**Deposit/Withdrawal Options**

**Bank Withdrawal Account**

**Direct Express MasterCard**

# Deposit / Withdrawal Options

**SOCIAL SECURITY BENEFIT PAYMENT PAID ON:**

**Box A - Required**

Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

<input type="checkbox"/> Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)	<input type="checkbox"/> Benefit paid on Second Wednesday (Option C)
<input type="checkbox"/> Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)	<input type="checkbox"/> Benefit paid on Third Wednesday (Option D)
	<input type="checkbox"/> Benefit paid on Fourth Wednesday (Option E)

Initial Draft Month \_\_\_\_\_ (Cannot exceed one benefit payment cycle past application date)

Select one of the 5 options using the Schedule of Social Security Benefit Payments.

**10-Day Rule**  
If the Social Security Benefit deposit date is within 10 business days of the in-house date, go to the next month for the initial draft month.

# Bank Withdrawal Account

<b>INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)</b>		
<b>Box B - Bank Withdrawal Account</b>		
Insured Name: _____	Birthdate of Insured: _____	
Payor Name if different than Insured: _____	Birthdate of Payor: _____	
	<input type="checkbox"/> Survivor Account	
Financial Institution Name, Office or Branch _____	Financial Institution Address City, State, Zip _____	
	Check One: <input type="checkbox"/> Checking <input type="checkbox"/> Savings \$ _____	
List All Authorized Account Holders _____	Premium amount _____	
Transit Routing Number _____	Account Number _____	Account Holder Signature _____

If choosing bank withdrawal option, all sections of Box B must be completed for form to be valid. We must have the birthdate of the insured and the payor to process. The birthdate of the payor is validated by checking it against the Schedule of Social Security Benefit Payments to ensure we have the correct payment date. If one, or both of the birthdates are not provided, placement of the policy and commissions could be delayed.

*Please note, a survivor account is when the original SS recipient has passed away and the spouse then receives the benefit payment. If using this option, please also fill out the DOB of the payor (deceased spouse) and checkmark survivor account box.*



# Direct Express MasterCard

Box C - Direct Express MasterCard		
Insured Name: _____	Birthdate of Insured: _____	
Payor Name if different than Insured: _____	Birthdate of Payor: _____	
5332 48 _____	<input type="checkbox"/> Survivor Account	
Direct Express MasterCard Account Number		
_____	\$ _____	Premium amount
Cardholder Signature	Date	
_____	_____	_____
Card Expiration Date	Mo/Yr	Cardholder Name ( Please Print)
_____	_____	_____

If choosing Direct Express Master card withdrawal option, all sections of Box C must be completed for form to be valid. We must have the birthdate of the insured and the payor to process. The birthdate of the payor is validated by checking it against the Schedule of Social Security Benefit Payments to ensure we have the correct payment date. If one or both of the birthdates are not provided, placement of the policy and commissions could be delayed.

Select one of the 5 payment date options using the Schedule of Social Security Benefit Payments. *Please note, we only accept Direct Express MasterCard Account Numbers beginning in 5332 48.*

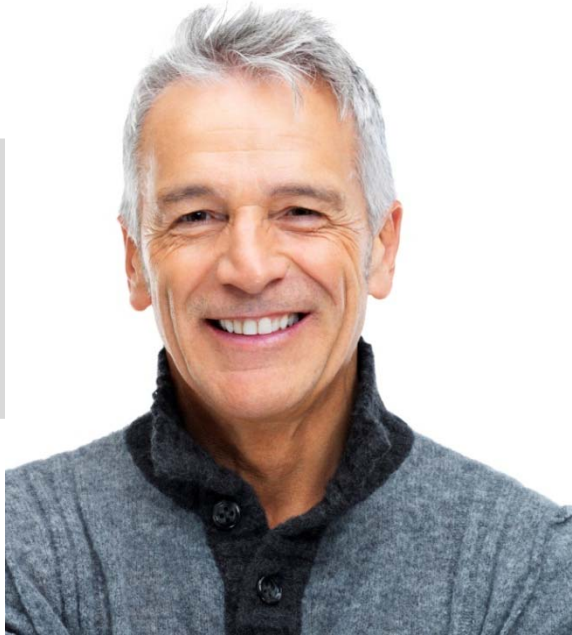
I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

\_\_\_\_\_  
Signature of Authorized Account Holder

\_\_\_\_\_  
Date



**Ben**

Birthdate: April 1, 1946

In-house Date: July 1, 2016

Payment Mode: Bank Withdrawal Account

# Schedule Of Social Security Benefit Payments 2016



JANUARY 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

MARCH 2016						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY 2016						
S	M	T	W	T	F	S
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8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 2016						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY 2016						
S	M	T	W	T	F	S
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3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2016						
S	M	T	W	T	F	S
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4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER 2016						
S	M	T	W	T	F	S
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2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22

NOVEMBER 2016						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26

DECEMBER 2016						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24

**Second Wednesday 1<sup>st</sup> – 10<sup>th</sup>**

Benefit pay on	Pay date on
Second Wednesday	1 <sup>st</sup> – 10 <sup>th</sup>
Third Wednesday	11 <sup>th</sup> – 20 <sup>th</sup>
Fourth Wednesday	21 <sup>st</sup> – 31 <sup>st</sup>

Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments

If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.

[www.socialsecurity.gov](http://www.socialsecurity.gov)

Social Security Administration  
SSA Publication No. 05-10031  
ICN 456100  
Unit of Issue - HD (one hundred)  
January 2015 (Recycle prior editions)

Printed on recycled paper

Using the Schedule of Social Security Benefit Payments determine the cycle that corresponds with the client's birthdate.

**Ben**

Birthdate: April 1, 1946

Ben's birthday falls between the 1<sup>st</sup> and the 10<sup>th</sup> of the month—therefore his Social Security Benefits are paid on the **second Wednesday** of the month.

**SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM**

Transamerica Financial Life Insurance Company  
440 Mamaroneck Avenue, Harrison, NY 10528

Transamerica Life Insurance Company

Transamerica Premier Life Insurance Company      **POLICY NUMBER** \_\_\_\_\_

Stonebridge Life Insurance Company  
Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

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**SOCIAL SECURITY BENEFIT PAYMENT PAID ON:**

**Box A - Required**

Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

Beneficiary receiving Supplemental Security Income (SSI)       Benefit paid on Second Wednesday (Option C)

1st of the month (Option A)       Benefit paid on Third Wednesday (Option D)

Benefits paid on 3rd of each month, started receiving SS       Benefit paid on Fourth Wednesday (Option E)

benefits prior to May 1997 or receiving both SS benefits and       Benefit paid on First Wednesday (Option F)

payments (Option B)

**Initial Draft Month** \_\_\_\_\_ (Cannot exceed one benefit payment cycle past application date)

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**INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)**

**Box B - Bank Withdrawal Account**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_

Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_

Survivor Account

Financial Institution Name, Office or Branch \_\_\_\_\_ Financial Institution Address City, State, Zip \_\_\_\_\_

List All Authorized Account Holders \_\_\_\_\_ Check One:  Checking  Savings \$ \_\_\_\_\_ Premium amount

Transit Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_ Account Holder Signature \_\_\_\_\_

---

**Box C - Direct Express MasterCard**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_

Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_

5332 48 \_\_\_\_\_  Survivor Account

Direct Express MasterCard Account Number \_\_\_\_\_ \$ \_\_\_\_\_ Premium amount

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_

Card Expiration Date \_\_\_\_\_ Mo/Yr \_\_\_\_\_ Cardholder Name ( Please Print) \_\_\_\_\_

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/ or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

Signature of Authorized Account Holder \_\_\_\_\_ Date \_\_\_\_\_

SSBA 0215

**Applicant Name**  
Ben Smith

**In-house Date**  
July 1, 2016

**Next Social Security Benefit Payment**  
July 13, 2016

**Will the next Social Security Benefit Payment occur after 10 business days of the In-house Date?**

No – we do not have ample time for the Company to approve/issue the policy before the next Social Security Benefit Payment.

**First Initial Draft Month**  
August

**Payment Mode**  
Bank Withdrawal Account





### **Marshall & Anita**

Marshall's Birthdate: June 22, 1944

Anita's Birthdate: February 14, 1949

In-house Date: July 1, 2016

Payment Mode: Direct Express MasterCard



Schedule Of Social Security Benefit Payments 2016



JANUARY 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY 2016						
S	M	T	W	T	F	S
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7	8	9	10	11	12	13
14	15	16	17	18	19	20
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28	29					

MARCH 2016						
S	M	T	W	T	F	S
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27	28	29	30	31		

APRIL 2016						
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MAY 2016						
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29	30	31				

JUNE 2016						
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5	6	7	8	9	10	11
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JULY 2016						
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3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST 2016						
S	M	T	W	T	F	S
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7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2016						
S	M	T	W	T	F	S
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18	19	20	21	22	23	24
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OCTOBER 2016						
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2	3	4	5	6	7	8
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NOVEMBER 2016						
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DECEMBER 2016						
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4	5	6	7	8	9	10
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18	19	20	21	22	23	24
25	26	27	28	29	30	31

Fourth Wednesday 21<sup>st</sup> – 31<sup>st</sup>

Third Wednesday 11<sup>th</sup> – 20<sup>th</sup>

If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.

ICN 456100  
Unit of Issue - HD (one hundred)  
January 2015 (Recycle prior editions)

www.socialsecurity.gov

Printed on recycled paper

Using the Schedule of Social Security Benefit Payments determine the cycle that corresponds with the client's birthdate.

**Marshall & Anita**

Marshall's Birthdate: June 22, 1944

Anita's Birthdate: February 14, 1949

Marshall's birthday falls between the 21<sup>st</sup> and the 31<sup>st</sup> of the month—therefore his Social Security Benefits are paid on the **fourth Wednesday** of the month.

Anita's birthday falls between the 11<sup>th</sup> and the 20<sup>th</sup> of the month—therefore her Social Security Benefits are paid on the **third Wednesday** of the month.

# Schedule Of Social Security Benefit Payments 2016



JANUARY 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

MARCH 2016						
S	M	T	W	T	F	S
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6	7	8	9	10	11	12
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27	28	29	30	31		

APRIL 2016						
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17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY 2016						
S	M	T	W	T	F	S
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8	9	10	11	12	13	14
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22	23	24	25	26	27	28
29	30	31				

JUNE 2016						
S	M	T	W	T	F	S
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12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY 2016						
S	M	T	W	T	F	S
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3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2016						
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11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER 2016						
S	M	T	W	T	F	S
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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER 2016						
S	M	T	W	T	F	S
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6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER 2016						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

**Fourth Wednesday | 21<sup>st</sup> – 31<sup>st</sup>**

Third Wednesday	11 <sup>th</sup> – 20 <sup>th</sup>
Fourth Wednesday	21 <sup>st</sup> – 31 <sup>st</sup>

receiving both Social Security benefits and SSI payments

*If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.*

[www.socialsecurity.gov](http://www.socialsecurity.gov)



Social Security Administration  
SSA Publication No. 05-10031  
ICN 456100  
Unit of Issue - HD (one hundred)  
January 2015 (Recycle prior editions)

Printed on recycled paper

Marshall and Anita specified they want both of their monthly premiums to be deducted from Marshall's Social Security Benefit Payments—or the **fourth Wednesday** of the Month.

Transamerica Financial Life Insurance Company  
 440 Mamaroneck Avenue, Harrison, NY 10528  
 Transamerica Life Insurance Company  
 Transamerica Premier Life Insurance Company  
 Stonebridge Life Insurance Company  
 Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

**SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM**  
 POLICY NUMBER \_\_\_\_\_

**SOCIAL SECURITY BENEFIT PAYMENT PAID ON:**

**Box A - Required**

Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)
  Benefit paid on Second Wednesday (Option C)

Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)
  Benefit paid on Third Wednesday (Option D)

Benefit paid on Fourth Wednesday (Option E)

Initial Draft Month \_\_\_\_\_ (Cannot exceed one benefit payment cycle past application date)

**INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)**

**Box B - Bank/Financial Institution**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_

Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_

Survivor Account

Financial Institution Name, Office or Branch \_\_\_\_\_ Financial Institution Address City, State, Zip \_\_\_\_\_

Check One:  Checking  Savings \$ \_\_\_\_\_ Premium amount

List All Authorized Account Holders \_\_\_\_\_

Transit Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_ Account Holder Signature \_\_\_\_\_

**Box C - Direct Express MasterCard**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_

Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_

Survivor Account

5332 48 \_\_\_\_\_  
 Direct Express MasterCard Account Number

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_ \$ \_\_\_\_\_ Premium amount

Card Expiration Date \_\_\_\_\_ Mo/Yr \_\_\_\_\_ Cardholder Name (Please Print) \_\_\_\_\_

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/ or such other payments as I may authorize the Companies to make. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

Signature of Authorized Account Holder \_\_\_\_\_ Date \_\_\_\_\_

SSBA 0215

**Applicant**  
Marshall Smith

**In-house Date**  
July 1, 2016

**Next Social Security Benefit Payment**  
July 27, 2016

**Will the next Social Security Benefit Payment occur after 10 days of the In-house Date?**  
Yes— we do have ample time for the Company to approve/issue the policy before the next Social Security Benefit Payment.

**First Initial Draft Month**  
July

**Payment Mode**  
Direct Express MasterCard—we only accept cards beginning with 5332 48.

Transamerica Financial Life Insurance Company  
 440 Mamaroneck Avenue, Harrison, NY 10528  
 Transamerica Life Insurance Company  
 Transamerica Premier Life Insurance Company  
 Stonebridge Life Insurance Company  
 Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

**SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM**  
 POLICY NUMBER \_\_\_\_\_

**SOCIAL SECURITY BENEFIT PAYMENT PAID ON:**

**Box A - Required**  
 Please select only one box to indicate the DEPOSIT/WITHDRAWAL option:

Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)  
 Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SS payments (Option B)  
 Benefit paid on Second Wednesday (Option C)  
 Benefit paid on Third Wednesday (Option D)  
 Benefit paid on Fourth Wednesday (Option E)

Initial Draft Month \_\_\_\_\_ (Cannot exceed one benefit payment cycle past application date)

**INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)**

**Box B - Savings Withdrawal Account**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_  
 Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_  
 Survivor Account

Financial Institution Name, Office or Branch \_\_\_\_\_ Financial Institution Address City, State, Zip \_\_\_\_\_  
 Check One:  Checking  Savings \$ \_\_\_\_\_ Premium amount

List All Authorized Account Holders \_\_\_\_\_  
 Transfer Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_ Account Holder Signature \_\_\_\_\_

**Box C - Direct Express MasterCard**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_  
 Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_  
 5332 48 \_\_\_\_\_  
 Direct Express MasterCard Account Number \_\_\_\_\_ \$ \_\_\_\_\_ Premium amount

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Card Expiration Date \_\_\_\_\_ Mo/Yr \_\_\_\_\_ Cardholder Name (Please Print) \_\_\_\_\_

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

Signature of Authorized Account Holder \_\_\_\_\_ Date \_\_\_\_\_

SSBA 0215

**Applicant**  
Anita Smith

**In-house Date**  
July 1, 2016—same as husband

**Next Social Security Benefit Payment**  
July 27, 2016—same as husband

**First Initial Draft Month**  
July—same as husband

**Payor**  
Marshall Smith is the payor for Anita Smith—therefore we require both of their birthdates and Marshalls signature.

**Payment Mode**  
Direct Express MasterCard—we only accept cards beginning with 5332 48.





## **Manny & Gloria**

Manny's Birthdate: July 5, 1959

Gloria's Birthdate: August 10, 1964

Application Date: July 1, 2016

Payment Mode: Bank Withdrawal Account



# Schedule Of Social Security Benefit Payments 2016



JANUARY 2016						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

MARCH 2016						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL 2016						
S	M	T	W	T	F	S
				1	2	
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY 2016						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 2016						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY 2016						
S	M	T	W	T	F	S
				1	2	
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST 2016						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2016						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER 2016						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER 2016						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER 2016						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

**Supplemental Security Income (SSI)**

- Second Wednesday 1<sup>st</sup> – 10<sup>th</sup>
- Third Wednesday 11<sup>th</sup> – 20<sup>th</sup>
- Fourth Wednesday 21<sup>st</sup> – 31<sup>st</sup>

Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments

If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.

[www.socialsecurity.gov](http://www.socialsecurity.gov)

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SSA Publication No. 05-10031  
ICN 456100  
Unit of Issue - HD (one hundred)  
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Printed on recycled paper

Using the Schedule of Social Security Benefit Payments determine the cycle that corresponds with the client's birthdate.

## Manny & Gloria

Manny's Birthdate: July 5, 1959

Gloria's Birthdate: August 10, 1964

Manny receives Supplemental Security Income (SSI) due to a disability—indicating SSI on the Payment cycle or the **first of the Month.**



Transamerica Financial Life Insurance Company  
 440 Mamaroneck Avenue, Harrison, NY 10528  
 Transamerica Life Insurance Company  
 Transamerica Premier Life Insurance Company  
 Stonebridge Life Insurance Company  
 Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

**SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM**  
 POLICY NUMBER \_\_\_\_\_

**SOCIAL SECURITY BENEFIT PAYMENT PAID ON:**

**Box A - Deposited**

Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

Beneficiary receiving Supplemental Security Income (SSI)     Benefit paid on Second Wednesday (Option C)  
 1st of the month (Option A)     Benefit paid on Third Wednesday (Option D)  
 Benefits paid on 3rd of each month, started receiving SS     Benefit paid on Fourth Wednesday (Option E)  
 Beneficiary receiving SS benefits starting on or after 1/1/1997 or receiving both SS benefits and SSI payments (Option B)

Initial Draft Month \_\_\_\_\_ (Cannot exceed one benefit payment cycle past application date)

**INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)**

**Box B - Bank Withdrawal Account**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_

Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_

Survivor Account

Financial Institution Name, Office or Branch \_\_\_\_\_ Financial Institution Address City, State, Zip \_\_\_\_\_

Check One:  Checking  Savings \$ \_\_\_\_\_ Premium amount

List All Authorized Account Holders \_\_\_\_\_

Transit Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_ Account Holder Signature \_\_\_\_\_

**Box C - Direct Express MasterCard**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_

Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_

5332 48 \_\_\_\_\_  Survivor Account

Direct Express MasterCard Account Number \_\_\_\_\_ \$ \_\_\_\_\_ Premium amount

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_

Card Expiration Date \_\_\_\_\_ Mo/Yr \_\_\_\_\_ Cardholder Name ( Please Print) \_\_\_\_\_

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/ or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

Signature of Authorized Account Holder \_\_\_\_\_ Date \_\_\_\_\_

SSBA 0215

**Applicant**  
Manny Smith

**In-house Date**  
July 1, 2016

**Next Social Security Benefit Payment**  
August 1, 2016

**Will the next Social Security Benefit Payment occur after 10 business days of the In-house Date?**

Yes— we do have ample time for the Company to approve/issue the policy before the next Social Security Benefit Payment.

**First Initial Draft Month**  
August

**Payment Mode**  
Bank Withdrawal Account

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 Transamerica Premier Life Insurance Company  
 Stonebridge Life Insurance Company  
 Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

**SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM**  
 POLICY NUMBER \_\_\_\_\_

**SOCIAL SECURITY BENEFIT PAYMENT PAID ON:**

**Box A - Required**  
 Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

Beneficiary receiving Supplemental Security Income (SSI)  Benefit paid on Second Wednesday (Option C)  
 1st of the month (Option A)  Benefit paid on Third Wednesday (Option D)  
 Benefits paid on 3rd of each month started receiving SS  Benefit paid on Fourth Wednesday (Option E)  
 Beneficiary receiving both SS benefits and SSI payments (Option B)

Initial Draft Month \_\_\_\_\_ (Cannot exceed one benefit payment cycle past application date)

**INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)**

**Box B - Bank Withdrawal Account**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_  
 Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_  
 Survivor Account

Financial Institution Name, Office or Branch \_\_\_\_\_ Financial Institution Address City, State, Zip \_\_\_\_\_  
 Check One:  Checking  Savings \$ \_\_\_\_\_ Premium amount

List All Authorized Account Holders \_\_\_\_\_

Transit Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_ Account Holder Signature \_\_\_\_\_

**Box C - Direct Express MasterCard**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_  
 Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_  
 5332 48 \_\_\_\_\_  Survivor Account  
 Direct Express MasterCard Account Number \_\_\_\_\_ \$ \_\_\_\_\_ Premium amount

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Card Expiration Date \_\_\_\_\_ Mo/Yr \_\_\_\_\_ Cardholder Name ( Please Print) \_\_\_\_\_

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

Signature of Authorized Account Holder \_\_\_\_\_ Date \_\_\_\_\_

SSBA 0215

**Applicant**  
Gloria Smith

**In-house Date**  
July 1, 2016—same as husband

**Next Social Security Benefit Payment**  
July 1, 2016—same as husband

**First Initial Draft Month**  
August – same as husband

**Payor**  
Manny Smith is the payor for Gloria Smith—therefore we require both of their birthdates and Mannys signature.

**Payment Mode - Bank Withdrawal Account**

# Schedule Of Social Security Benefit Payments 2016



JANUARY 2016							FEBRUARY 2016							MARCH 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	1	2	3	4	5			
3	4	5	6	7	8	9	7	8	9	10	11	12	13	6	7	8	9	10	11	12
10	11	12	13	14	15	16	14	15	16	17	18	19	20	13	14	15	16	17	18	19
17	18	19	20	21	22	23	21	22	23	24	25	26	27	20	21	22	23	24	25	26
24	25	26	27	28	29	30	28	29						27	28	29	30	31		
31																				

APRIL 2016							MAY 2016							JUNE 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	7	1	2	3	4			
3	4	5	6	7	8	9	8	9	10	11	12	13	14	5	6	7	8	9	10	11
10	11	12	13	14	15	16	15	16	17	18	19	20	21	12	13	14	15	16	17	18
17	18	19	20	21	22	23	22	23	24	25	26	27	28	19	20	21	22	23	24	25
24	25	26	27	28	29	30	29	30	31					26	27	28	29	30		

JULY 2016							AUGUST 2016							SEPTEMBER 2016						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	1	2	3	4	5	6		
3	4	5	6	7	8	9	7	8	9	10	11	12	13	4	5	6	7	8	9	10
10	11	12	13	14	15	16	14	15	16	17	18	19	20	11	12	13	14	15	16	17
17	18	19	20	21	22	23	21	22	23	24	25	26	27	18	19	20	21	22	23	24

## Access the Schedule of Social Security Benefit Payments & Social Security Benefit Billing Authorization Form

30	31																			
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Benefits paid on	Birth date on	<input type="checkbox"/> Supplemental Security Income (SSI)
<input checked="" type="checkbox"/> Second Wednesday	1 <sup>st</sup> - 10 <sup>th</sup>	<input type="checkbox"/> Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments
<input type="checkbox"/> Third Wednesday	11 <sup>th</sup> - 20 <sup>th</sup>	
<input type="checkbox"/> Fourth Wednesday	21 <sup>st</sup> - 31 <sup>st</sup>	

If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.

[www.socialsecurity.gov](http://www.socialsecurity.gov)

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**SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM**  
 POLICY NUMBER \_\_\_\_\_

**SOCIAL SECURITY BENEFIT PAYMENT PAID ON:**

**Box A - Required**  
 Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:  
 Beneficiary receiving Supplemental Security Income (SSI)  Benefit paid on Second Wednesday (Option C)  
 1st of the month (Option A)  Benefit paid on Third Wednesday (Option D)  
 Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)  Benefit paid on Fourth Wednesday (Option E)

Initial Draft Month \_\_\_\_\_ (Cannot exceed one benefit payment cycle past application date)

**INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)**

**Box B - Bank Withdrawal Account**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_  
 Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_  
 Survivor Account

Financial Institution Name, Office or Branch \_\_\_\_\_ Financial Institution Address City, State, Zip \_\_\_\_\_  
 Check One:  Checking  Savings \$ \_\_\_\_\_  
 Premium amount

List All Authorized Account Holders \_\_\_\_\_  
 Transit Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_ Account Holder Signature \_\_\_\_\_

**Box C - Direct Express MasterCard**

Insured Name: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_  
 Payor Name if different than Insured: \_\_\_\_\_ Birthdate of Payor: \_\_\_\_\_

the grace period allowed by a policy, the policy may terminate.  
 As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.  
 This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

Signature of Authorized Account Holder \_\_\_\_\_ Date \_\_\_\_\_

SSBA 0215



Transamerica Financial Life Insurance Company is authorized to conduct business in New York. Transamerica Life Insurance Company and Transamerica Premier Life Insurance Company are authorized to conduct business in all other states.

Immediate Solution 121, 10-Pay Solution and the Easy Solution are whole life insurance policies issued by Transamerica Financial Life Insurance Company, Harrison, NY 10528 in New York and by Transamerica Life Insurance Company or Transamerica Premier Life Insurance Company, Cedar Rapids, IA 52499 in all other jurisdictions. Policy Form Nos. WL08 and WL09. Policy form and number may vary, products and riders may not be available in all jurisdictions. Insurance eligibility and premiums are subject to underwriting.