EFT AUTHORIZATION AGREEMENT

*The purpose of this authorization is to allow the Company to electronically transfer funds from the **named insured's** account as a result of insurance transactions between the Company and the policyholder.*

I hereby authorize hereinafter called COMPANY, to initiate debit and/or credit entries to my account indicated below and the depository, hereinafter called DEPOSITORY to debit/credit the same to such account.

☐ NEW - This is a new request to start having payments automatically drafted from my account

☐ CHANGE - This is to change the account on which the automatic drafting is done

☐ REMOVE - Stop automatic drafting of payments from my account - please allow 5 business days

Complete the below for Checking and Savings Accounts		Complete the below for Credit/Debit Card	
Account Type:	☐ Checking ☐ Savings	**Account Type:**	☐ MasterCard ☐ VISA ☐ Discover
Bank Name:		**Name on Card:**	
Name on Account:		**Account Number:** (16 Digits)	
Routing Number: (9 Digits)		**Expiration Date:**	**CVV:**
Account Number:		**Billing Address:**	
		State:	**Zip:**

This authorization is to remain in full force and effect until COMPANY has received written notification from me of termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act. I may only revoke this authorization by contacting COMPANY directly.

I or COMPANY have the right to stop payment of a debit entry by notification to DEPOSITORY and COMPANY at such time as to afford DEPOSITORY and COMPANY a reasonable opportunity to act on it prior to charging the account. After the account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by DEPOSITORY, provided I send written notice of such debit entry in error to DEPOSITORY and COMPANY within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first.

COMPANY shall not be responsible for any errors of the DEPOSITORY or of its agents, employees, or intermediaries, unless such errors are caused by the negligence or willful misconduct of COMPANY.

NOTE: Changes to your policy that result in additional premium will be drafted from your account one day after processing. I understand that it is my responsibility to make sure that the funds are available in my account when payment is due. Failure to do so will result in NSF fees and/or cancellation of my ACH privileges. This agreement does not reinstate any cancellation. Installments due prior to today may not be automatically drafted, and should be remitted to the company directly. If the past due installment has not been cured and the completed authorization is received by the company after the non-pay cancellation effective date, the policy will remain cancelled.

Policy Number: _____ **Insured Name:** _____

Account Holder Signature: _____

Date/Time: _____