



AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

I (we) hereby authorize EQUITY INSURANCE COMPANY, their affiliates and subsidiaries, hereafter called COMPANY, to initiate monthly deductions from my checking or savings account, indicated below, for payment of premium on the insurance policy issued to me (us) by COMPANY, and any renewals thereof, and to indicate credit entries to my (our) account in order to correct any erroneous deductions or provide a refund of premium. I (we) authorize the financial institution named below as the DEPOSITORY, to accept and post entries to my account.

I (we) understand this authorization allows **COMPANY** to adjust the monthly deductions to reflect any premium changes and policy renewals. **COMPANY** agrees that it shall notify me (us) at least ten days prior when any deductions will be less than the previous deduction by more than one thousand dollars or when any deduction will be greater than the previous deduction. I (we) acknowledge receipt of this authorization form.

Select a payment withdrawal date:

Choose any date + or - 5 days from the effective date of the policy, **excluding the 29th, 30th, and 31st.**

Examples:

- a. If the policy is effective on the 15th of the month, choose dates of the 10th thru the 20th.
- b. If the policy is effective on the 25th of the month, choose dates of the 20th thru the 28th.

The 29th, 30th and 31st are excluded and not available as payment withdrawal dates.

NOTE: If no date is chosen, we will use the date 30 days after the effective date of the policy.

Requested Payment Withdrawal Date: _____

Insured Name: _____ Policy # _____

Checking Account

1. Attach the down payment check to the:
 - a. New Business Application or
 - b. Renewal Request or
 - c. Rewrite Request

2. Attach a voided check here.

Savings Account

1. Attach the down payment check to the:
 - a. New Business Application or
 - b. Renewal Request or
 - c. Rewrite Request

2. Attach copy of Savings Account Card or Savings Account Deposit Slip here.

This authorization is to remain in full force and effect until I terminate it by giving the **COMPANY** and my **DEPOSITORY** written notification of the termination in such time and in such manner so that **COMPANY** and my **DEPOSITORY** has reasonable opportunity to act on such notification.

Note: A minimum of two weeks written notice is required to terminate this authorization.

Signature: _____

Named Insured

Named Insured must also be the Checking or Savings Account Holder.