AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

I (we) hereby authorize Nations Insurance Company to initiate electronic debit and credit entries to my (our) checking account identified below. This authority pertains to payment of premium on the insurance policy and any renewals thereof, issued to me (us) by Nations Insurance Company. I (we) understand that this authorization allows Nations Insurance Company to adjust the debit and credit entries to reflect any premium changes including policy renewals. I (we) understand that this authorization allows Nations Insurance Company to deduct from my (our) checking account any amount due including earned premiums should my (our) insurance coverage be canceled for any reason.

I (we) understand that both the financial institution and Nations Insurance Company reserve the right to terminate this payment plan and/or my (our) participation therein at any time. Invalid account information or non-sufficient funds will result in automatic termination of the EFT and will require that all subsequent payments be mailed to Nations Insurance Company. I too, can elect to discontinue my participation in this plan providing written notice to Nations Insurance Company within a sufficient amount of time to afford Nations Insurance Company and the named financial institution to act on it prior to the next payment date.

I (we) understand that EFT is not effective immediately. I (we) will be notified when the EFT becomes effective. Until then all payments for premium due statements (bills) issued, still need to be mailed to Nations Insurance Company. I (we) also understand that monthly premium due statements (bills) will no longer be mailed once my (our) account has been setup for EFT. I (we) also understand that my policy will cancel or expire if there are insufficient funds in the account noted below or if the account is closed or no longer valid. Non-sufficient funds or invalid account information on new or renewal down payments will result in the policy being cancelled flat (coverage rescinded) which means that no coverage will be provided.

1. Policy Number: _____

2. Signature of Account Holder: _____ Date: _____

3. Name(s) on Account: _____

4. Name of Financial Institution: _____

5. Branch Address of Financial Institution: _____

6. Routing/Transit/ABA # _____

7. Account # _____

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To ensure accuracy, please attach a sample check marked VOID from the bank account you have selected above. Customers of credit unions should verify their account number through their local office as many credit unions use a different account number that the one reflected on the check.

Attach Voided Check Here
(Deposit Slips or Commercial checks do not qualify)

ABA Number Checking account number

Incorrect or incomplete information may result in the policy being issued on a Direct Bill Payment Plan