

EFT AUTHORIZATION FORM

Insured Name: _____ Policy # _____
(last name) (first name)

Agent Code: _____ Policy Effective Date: __/__/__

Mailing Address: _____

TELEPHONE #: (____) - _____ - _____

**Please provide us with your daytime telephone number so that we may reach you to verify information. Commerce will not give out your telephone number to any third parties.

Monthly deductions to be taken from: Checking Account Statement Savings Account

Bank Name: _____

Bank Transit / ABA#									Bank Account Number									

Your bank/ABA number will always be 9 digits and will begin and end with these marks | :

Account Holder Name: _____
(If different than Insured)

DATE YOU WISH TO HAVE PREMIUM PAYMENTS DEDUCTED FROM YOUR ACCOUNT:
(PLEASE CIRCLE ONE)

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

EFT AGREEMENT

I authorize and request the Commerce Insurance Company to debit my bank account as payments on this policy or its replacement become due. If a debit is dishonored, the bank will not have any liability, even if the dishonored payment causes the cancellation of my insurance policy. I will be charged the applicable return transaction fee when payments are dishonored. This authority is to remain in full force until Commerce Insurance Company and the bank have each received written notice from me of its termination, in such time and manner as to afford Commerce Insurance Company and the bank a reasonable time to act upon it. You may not designate the account of your agent, broker, or exclusive representative producer for premium withdrawals. Commerce reserves the right to disapprove the bank account you use for withdrawals. By signing this authorization, I acknowledge that I have read and agree to the conditions set forth in this agreement.

Signature of Account Holder
(If different than Insured)

Date

Insured Signature

Date

YOU MUST ATTACH A VOIDED CHECK IF DEDUCTIONS ARE FROM A CHECKING ACCOUNT.

THE INFORMATION IN THIS BOX IS FOR AGENT/COMPANY USE ONLY	
PLEASE BE CERTAIN TO ATTACH THIS FORM TO THE FRONT OF APPLICATION OR DECLARATION PAGE	
<input type="checkbox"/> NEW BUSINESS EFT (Down Payment of 12% must be submitted with application)	
<input type="checkbox"/> RENEWAL/BOOK TRANSFER EFT (Submitted 45 days prior to policy effective date)	
<input type="checkbox"/> MID TERM TRANSFER (Current policy from Direct Bill to EFT for policies effective 1/1/99 or after)	
<input type="checkbox"/> NEW BANK INFORMATION (For existing EFT policy)	
<input type="checkbox"/> NEW DEDUCTION DATE (For existing EFT policy)	
<input type="checkbox"/> CONVERT EFT POLICY TO DIRECT BILL 10 PAYMENT PLAN	Company/Agt. Rep. _____