

EFT AUTHORIZATION FORM

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

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 (Please attach a voided check)
- Monthly Statement Savings Account (No passbook accounts please)

Bank Name: _____

Bank Transit / ABA#								

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

Checking or Savings Account Number								

Account Holder Name _____
(If different than Insured) PLEASE PRINT

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

1 15 28

EFT AGREEMENT

I authorize the Commerce Insurance Company to debit my bank account as payments on this policy or its replacement become due. I understand that 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 above named 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 use the account of your insurance agent or broker for EFT deductions. Commerce reserves the right to disapprove the 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)

Insured Signature _____

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"/> NEW BANK INFORMATION (For existing EFT policy)		
<input type="checkbox"/> NEW DEDUCTION DATE (For existing EFT policy)		
<input type="checkbox"/> REMOVE POLICY FROM EFT PAYMENT PLAN (Please specify new bill plan)		
<input type="checkbox"/> 10 Pay	<input type="checkbox"/> 4 Pay	<input type="checkbox"/> Full Pay
Agent: _____		