FORWARD
Mutual Insurance Company

Electronic Funds Transfer (EFT) Authorization Form

Billing Information

Insured Name(s):_____

Billing Address: _____

City, State, Zip: _____

Cell #: _____ Email: _____

Policy #: _____ Policy Effective Date: _____

☐ **New EFT Setup – EFT Fee is $1.00 per month and you must submit a down payment of 10% of the total annual policy premium with this authorization form.**

Bank Details

Monthly deductions to be taken from:

☐ **Checking**

Note: A picture image of your check showing account number and routing number is recommended.

Account Name: _____

Bank Name: _____

Account Number: _____

Routing Number: _____

Select the day of the month listed below on which Forward Mutual should withdraw the monthly premium.
The day of the month selected must be on or before the due date of your premium.
If you do not specify a date, we will select one.

☐ **4th** ☐ **10th** ☐ **15th** ☐ **23rd** ☐ **28th**

EFT AUTHORIZATION AGREEMENT

I authorize Forward Mutual Insurance Company (FMIC) to initiate scheduled deductions from the bank account, identified above, for payment of premium on the insurance policy issued to me by FMIC, and any renewals thereof, and to initiate credit entries to the account to correct any erroneous deductions or provide a refund of premium. I authorize the bank (financial institution) identified by the routing number above to accept and post entries to the account. I represent that I am the account holder (owner) and/or an authorized signer on the account.

I understand that this authorization allows FMIC to adjust the scheduled deductions to reflect any premium changes. FMIC agrees that it shall notify me at least ten (10) days prior to making any deduction that will be less or greater than the previous deduction.

I understand that FMIC will not send me a bill before scheduled deductions are made and that it is my responsibility to ensure sufficient funds are in the account at the time of each scheduled deduction. I will be charged a $10 return transaction fee when payments are dishonored. I also understand that my policy may cancel or expire if there are insufficient funds in the account.

I acknowledge that the origination of ACH (Automated Clearing House) transactions to the account must comply with the provisions of U.S. law.

This authorization will remain in effect until I notify FMIC of its termination, either in writing, electronically or by calling an FMIC representative, in such time and manner as to afford FMIC a reasonable opportunity to act on it.

X _____ _____
ACCOUNT HOLDER'S SIGNATURE DATE