ACORD™ PREMIUM PAYMENT SUPPLEMENT

DATE (MM/DD/YYYY)

AGENCY

APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4)

COMPANY

POLICY #

CODE: SUBCODE:

AGENCY CUSTOMER ID

IS THE PREMIUM FINANCED? ☐ YES ☐ NO

FINANCE COMPANY

PAYMENT INTERVAL
☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ BI-MONTHLY ☐ MONTHLY ☐ 40-30-30 ☐ OTHER:

PAYMENT DUE DATES:

PAYMENT METHOD - SELECT ONE:

☐ 1. VERBAL CHECK

BANK/ABA # ACCOUNT # CHECK # PREMIUM PAYMENT AMOUNT $ .00

☐ 2. ELECTRONIC FUNDS TRANSFER

BANK/ABA # ACCOUNT # ACCOUNT TYPE ☐ PREMIUM PAYMENT AMOUNT $ .00

☐ 3. MAIL-IN CHECK

CHECK # PREMIUM PAYMENT AMOUNT $ .00

☐ 4. PAYROLL DEDUCTION

BANK/ABA # ACCOUNT # PREMIUM PAYMENT AMOUNT $ .00 # DEDUCTIONS

EMPLOYEE ID # EMPLOYER NAME AND ADDRESS BILLING LOCATION NO.

☐ 5. CREDIT CARD DEDUCTION

☐ AMERICAN EXPRESS ☐ DISCOVER ☐ MASTERCARD ☐ VISA ☐ OTHER: _____

ACCOUNT # EXP DATE

For submission methods 1 and 2:

1. Does the payor require a physical record of this transaction? ☐ YES ☐ NO
2. To ensure accuracy, a voided check or deposit slip (of the payor) should be attached to this supplement.
3. The undersigned Applicant certifies that by signing this application he/she authorizes the company named above to deduct or has obtained financial information and authorization from the payor to direct the company named above to deduct the Premium Payment Amount, and any other monies required to bind coverage, from the bank, credit card or payroll account, and the account number as indicated above for purposes of securing insurance pursuant to this application.

REMARKS

APPLICANT SIGNATURE	DATE	PRODUCER SIGNATURE

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