

## ***Checkless Pay Application Customer Information***

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Insured's Name

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Policy #

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Policy #

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Policy #

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Daytime Phone #

### ***Bank Information***

Please check one

Name(s) on bank account

Checking

Savings

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Name of Bank/Credit Union

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Account #

***Deduct Date Desired:***

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Day of month

#### **AUTHORIZATION AND AGREEMENT FOR CHECKLESS PAY**

I authorize Enumclaw Insurance Group to instruct the financial institution on which my voided check or savings withdrawal slip is drawn, to automatically deduct a payment from my checking or savings account each month. The amount will be deducted and transmitted to Enumclaw Insurance Group as payment of my insurance premium. I understand that the institution has no obligation to make such deduction unless full funds are available. I make this authorization subject to the following conditions:

- I have the right to recover the amount of any erroneous Enumclaw Insurance Group deduction either by check or as a credit to my account.
- This agreement is continuous until terminated unless any transaction is not honored by the financial institution designated.
- This authorization may be terminated at any time by me or Enumclaw Insurance Group by written notice to the other party.
- Enumclaw Insurance Group will provide me written notification when the deduction amount changes by more than \$1.00.

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Signature \*

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Date

\* Reminder: Have you attached your voided check or savings withdrawal slip?