



Authorization Agreement For Electronic Payment (EFT)

Insured's Name _____

Policy Number _____

E-Mail _____

I (we) hereby authorize Advocate, MD Insurance of the Southwest Inc. to initiate debit entries to account indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination to ACH transactions to the account must comply with the provisions of the U.S. law.

Electronic debiting shall be initiated by Advocate, MD Insurance of the Southwest Inc. for premium payments for the above listed policy. No payment to Advocate, MD shall be deemed to have been made unless and until Advocate, MD receives actual notification of credit on the below account. I understand my direct electronic payment will be debited monthly and I (we) am responsible for immediately notifying Advocate, MD for any changes to the account below.

DEPOSITORY

Name _____

Branch _____

City _____

State _____ Zip _____

Account Type (circle one) Checking Savings

Account Description (circle one) Corporate Personal

Routing Number _____

Account Number _____

Date _____

Signature _____

Please enclose this authorization and a voided check with your quote letter and payment in the envelope provided directly to the Accounting Department. Subsequent changes to this form may be sent via fax to Accounting Department at (512) 275-1241.

Note: Advocate, MD Insurance of the Southwest Inc. reserves the right to refuse or terminate electronic payment services. This agreement shall remain in full effect until Advocate, MD Insurance of the Southwest Inc. receives written notification from you 30 days in advance of the termination date. A \$25.00 fee will be charged to your account for insufficient funds.