

ARMS Insurance Agency, Inc.
Electronic Funds Transfer (EFT) Authorization

I authorize **Arms Insurance Agency, Inc.** ("Agency") to initiate scheduled deductions from the bank account, identified below, for payment of premium on the insurance policy issued to me by the Agency, 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 **\$25.00 or 1.1% of the transfer, whichever is the lesser, as a convenience fee** for each transfer to be included in the amount below. I authorize the financial institution identified by the routing number below to accept and post entries to the account. I represent that I am the owner and/or an authorized signer on the account.

I understand that this authorization allows Agency to adjust the scheduled deductions to reflect any premium charges. Agency agrees that it shall notify me at least five (5) days prior to making any deduction that will be less or greater than the previous deduction by more than \$1,500.

I understand that Agency 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 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.

Bank Information (*Attach copy of - void - Check*)

Name on account: _____ Checking
Account number: _____ Savings
Routing number: _____ Business Account
 Personal Account

This authorization will remain in effect until I notify Agency of its termination, in writing, in such time and manner as to afford Agency reasonable opportunity to act on it.

Signature (must be a person authorized to sign on this account)

Date

X _____ / ____ / _____

Important Notice for Credit Union Members: Many smaller credit unions use a different account number than the one shown on your check. You may wish to verify your account number through your local office to assure proper setup for withdrawals.

Insured Name: _____

Policy Number(s) _____

Scheduled Deductions: One Time Monthly Bi-weekly Weekly

Scheduled Day: _____ (I-30) _____ (M-F)

Scheduled Payments: \$ _____ D/P Inst = *\$ _____ *Convenience Fee Included*

Total Payment Due: \$ _____

***** For security purposes, fax ALL PAYMENT forms to 616 954-0732. All other paperwork fax to 616 954-9855 *****