



# One Time ACH Payment Authorization

Sign and complete this form to authorize First Benefits Insurance Mutual, Inc. to make a one (1) time debit to your checking or savings account.

By signing this form, you give us permission to debit your account for the amount indicated on or after the date indicated. This is permission for a single transaction only and does not provide authorization for any additional unrelated debits or credits to your account.

I \_\_\_\_\_ authorize First Benefits Insurance Mutual, Inc. to charge my  
(Full Name)

bank account indicated below for \$ \_\_\_\_\_ on \_\_\_\_\_  
(Amount) (Date – mm/dd/yyyy)

This payment is for the monthly workers' compensation premium for:

Name of Insured \_\_\_\_\_ Policy # \_\_\_\_\_

## Billing Information

Billing Address \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email: \_\_\_\_\_

## Bank Details

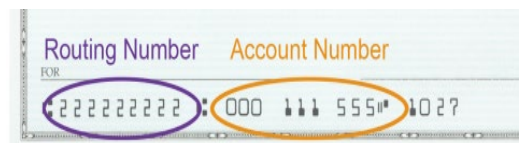
Checking Savings

Account Name \_\_\_\_\_

Bank Name \_\_\_\_\_

Account Number \_\_\_\_\_

Routing Number \_\_\_\_\_



I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted transaction date. In the case of the payment being rejected for Non-Sufficient Funds (NSF) I understand that First Benefits Insurance Mutual, Inc. may, at its discretion, attempt to process the charge again within 30 days. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I will not dispute First Benefits Insurance Mutual, Inc. billing with my bank so long as the transaction corresponds to the terms indicated in this agreement.

SIGNATURE \_\_\_\_\_  
(Account Holder's Signature)

DATE \_\_\_\_\_