Automatic Payment Authorization Form

Complete Parts 1, 2 and 3 to START or CHANGE Automatic Payment. Complete Steps 1 and 3 to CANCEL.

STEP 1: Provide Policy Information

Policy Number:_____

Please list all polices requesting Auto Pay

Policyholder Name:_____

Policyholder Email Address:_____

Check one: ☐ **Start** Auto Payment ☐ **Change Existing** Auto Payment ☐ **Cancel** Auto Payment

PAYMENT PLAN

_____ **Recurring Monthly Payment** – 20% of premium due at inception, remaining ten (10) installments processed monthly, service charge is waived. All processed by Automatic Deduction.

_____ **Recurring Four Payment –** 40% of premium due at inception, and the remainder processed in three (3) 20% quarterly installments, service charge is waived. All processed by Automatic Deduction

STEP 2: Provide banking information

BANK INFORMATION

Bank Name:_____ Phone Number: ( )_____

Bank Address:_____

Name of Checking or Savings Account Holder:_____

☐ Check Account ☐ Savings Account

Nine (9) Digit Routing Number:_____ Account Number:_____

PLEASE ATTACH VOIDED CHECK OR SAVINGS ACCOUNT WITHDRAWAL SLIP TO THIS FORM

PAYMENT AUTHORIZATION

I authorize **California Mutual Insurance Company** and the financial institution named above to initiate entries to the checking or savings account indicated for the billed amount on my insurance policy. This authorization will remain in effect until I notify you to cancel my Automatic Payment a minimum of three (3) business days before the due date, either orally or in writing via the address phone or fax numbers below. I understand that the debit entries (automatic payments) vary for reasons including but not limited to endorsements, renewals and cancellations.

I understand that this payment plan may be cancelled by the Service Provider or California Mutual Insurance due to Non-Sufficient Funds (NSF) and I will be liable to pay a $25.00 NSF fee (or amount allowable by law) which may be automatically debited for each NSF.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the Service Provider, the Bank and California Mutual Insurance Company harmless from damage, loss or claim resulting from al authorized actions hereunder.

Authorized Signature:_____ Authorized Signature:_____
(If second required by bank)

Print Name:_____ Print Name:_____

Date:_____ Date:_____

STEP 3: Send completed form with a voided check or savings account withdrawal slip:

• Fax – 831-637-1406 • Email – Frontdesk@calmutual.com • Mail – California Mutual Insurance Co
P.O. Box 1326, Hollister, CA 95024

Ver. 07 12