Auto Pay Authorization Form

ARBELLA INSURANCE GROUP

This form must be completed in its entirety, if received incomplete it will be returned without being processed.

Enroll ☐	***Change*** ☐	***Delete*** ☐
Insured / Business Name:		
Address:		
City:	**State:**	**Zip:**
Policy Number(s):		

If you choose to sign the Electronic Funds Transfer (EFT) Authorization below, we will automatically deduct your monthly premium payment for the indicated policies and renewals thereof on a monthly basis from your designated account in an amount equal to your current monthly premium payment. If your monthly premium payment changes by more than $1.00, we will send you an updated notification. If your financial institution does not honor a withdrawal, your premium due will be considered unpaid. It may take up to 30 days for your Auto Pay plan to begin.

Your due day is set to your policy effective date, except for CT home/condo/renters and CT automobile which is either the 5th or the 20th, whichever is closest to your policy effective date. Your deductions are withdrawn from your account on approximately the same day each month. If your scheduled payment falls on a weekend or holiday, your payment will be made on the following business day. If you have any questions regarding Electronic Funds Transfer (EFT), we are here to help you, please contact our Customer Service Department at 1-800-ARBELLA (1-800-272-3552).

If you have an outstanding bill, **it must be paid to keep your policy active before EFT deductions can begin**. You will be notified when your Auto Pay enrollment, change or delete has been processed.

Bank Name:										
Name on Bank Account:										
Bank Account Type: ***Checking*** ☐ ***Savings*** ☐										
Bank Account Number:										
Bank Transit/Routing Number (9 Digits**):**										

Deduction Authorization

By signing below I authorize Arbella Mutual Insurance Company, or its affiliates, to initiate monthly premium payments by withdrawals from my bank account at the financial institution identified above in the amount of my current monthly premium. I also authorize the above financial institution to accept such withdrawal instructions and debit my bank account and understand changes to my policy may change the amount debited. This authorization is effective as of the date hereof and will remain in effect until I provide written, electronic or telephone instructions to terminate such authorization to Arbella. A delete request must be received within a reasonable time in order to allow Arbella to terminate such authorization.

By signing below, I represent that I am the owner and/or authorized signer on the bank account identified above, I am agreeing to the terms and conditions of the above EFT Authorization and I am entering into a legally binding agreement.

Print Name and Title of authorized signatory (if commercial policy)	
Signature of Authorized Signatory (if different than insured)**:**	**Date:**
Insured Signature:	**Date:**

Fax To: 617-793-9081 Please retain a copy for your records **Mail To:** Arbella Insurance
P.O. Box 699103
Quincy, MA 02269-9225