

## Wesco Insurance Company

### Authorization Agreement for Direct Payments

I (we) hereby authorize Wesco Insurance Company to initiate monthly deductions from my (our) account, identified below, for payment of premium on the insurance policy issued to me (us) by Wesco Insurance Company. I (we) authorize the financial institution named below to accept and post entries to my (our) account.

I (we) understand that the monthly deductions will be processed as an electronic funds transfer and made on the 10th day of each month. If this date falls on a date that is not a business day, the applicable date shall be the following business day.

I (we) understand that this authorization allows Wesco Insurance Company to adjust the monthly deductions to reflect any premium changes with the exception of the final premium audit. Any additional premiums resulting from the final premium audit will be invoiced directly to me (us). Technology Insurance Company agrees to notify me (us) of all deductions being processed.

I (we) understand that any refunds due on the policy listed below will be refunded by check and not through electronic transfer.

I (we) understand that if renewal policies are issued, that this authorization will extend to that policy term unless I (we) provide written notice to Wesco Insurance Company of a request to terminate this authorization.

I (we) understand that if payment is dishonored by the bank designated below from the account specified this agreement may be considered cancelled and the dishonored payment and all remaining payments may be required to be made by check or other negotiable instrument to ensure the continuance of my (our) coverage. All payments must be paid as invoiced.

Insurance Name: \_\_\_\_\_

PolicyNumber: \_\_\_\_\_

Policy Term: \_\_\_\_\_

#### Bank Information

Name(s) on Account: \_\_\_\_\_

Type of Account:                      Checking                      Savings \_\_\_\_\_

Name of Financial Institution: \_\_\_\_\_

Routing / ABA #: \_\_\_\_\_

Account #: \_\_\_\_\_

This authorization will remain in effect until I (we) provide written notice to Technology Insurance Company of its termination in such time and in such manner as to afford Technology Insurance Company a reasonable opportunity to act on it.

Signature of Insured / Policy Holder \_\_\_\_\_

Date \_\_\_\_\_

**Please allow five (5) business days for processing of this authorization.**

**To ensure accuracy, please attach a sample check or deposit slip marked 'VOID'.**

Please fax or mail this form to:

Secured Accounting Fax Only – 800-487-9654

E-mail – AmtrustAR@amtrustgroup.com

Mail to –

Wesco Insurance Company  
Attn: Accounts Receivable  
P.O. Box 31880  
Cleveland OH 44131-0880