# APPLICANT AUTHORIZATION

Association dues of $1.00 and administrative fees of $4.00 (per month) must be added to the premium amount collected.A service charge of $20 per incomplete transaction will be imposed for NSF, Stop Pay, Closed Account or Declined credit card.

## A. CREDIT CARD BILLING:

I authorize you to charge my insurance premiums, as provided to me by the insurer, on a monthly basis to the following credit card. I understand that if I wish to discontinue this authorization or if my credit card number changes, I will notify in writing ISM Administrators.

☐ MasterCard ☐ VISA

Credit Card Number | | | | | | | | | | | | | | | | | | | |

Signature: _____ Expiration Date: _____ 3 Digit Security Code _____

## B. ELECTRONIC FUNDS TRANSFER

I wish to have my monthly premium deducted from the checking account number shown below. I authorize my bank to withdraw the appropriate premium and fees on a monthly basis. I understand that if I wish to discontinue this authorization or my checking account number changes, I will notify ISM Administrators in writing. My personal check payment may be converted to an electronic payment processed through the Automated Clearing House Network (ACH). My payment will be reflected on my financial institution's monthly account statement as an electronic payment in the amount of my check, and will reference the check number I use to make this payment. For further information or to opt-out of the electronic check program I understand that I must call (800)488-1474 during regular business hours. **Anti-Money Laundering regulations imposed by the federal government as part of the Patriot Act prohibit the payment of insurance premiums by cashier's check or money order.**

**I authorize ACH payment of initial premium in lieu of a personal check or credit card if not included with my application.**

Account # _____ Routing # | | | | | | | | | |

Signature of Depositor: _____
(as it appears on checking account)

## C. PAYROLL DEDUCTION (Minimum 3 Lives)

To _____
Employer

I hereby authorize you to deduct from my salary or wages the amount necessary to pay the required premium and fees, and to remit that amount to ISM Administrators. I request that this authorization remain in effect until such time as I withdraw it by giving written notice prior to the next premium due date.

## D. DIRECT BILL: (annual only)

Insured's Name: _____

Billing Address: _____ City _____ State _____ Zip Code _____
(If different from the first page)

Insured's Signature:

_____

## AGENT INFORMATION

Writing Agent Name **(Print)**: CODE #

_____

Agent Address:

_____

Tax ID. (if none, Social Security Number.): _____