



**MAPFRE Insurance Company**

P.O. Box 8006, Pleasanton, CA 94588-8606

[www.mapfreinsurance.com](http://www.mapfreinsurance.com)

1-877-MAPFRE1

## EFT AUTHORIZATION FORM

Insured Name: \_\_\_\_\_ Policy # \_\_\_\_\_  
(Last name) (First Name)

Policy Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone #: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ E-mail Address \_\_\_\_\_

\*\* We may provide your e-mail address or telephone number to your independent insurance agent or broker, or to nonaffiliated third parties who are non-financial companies that provide services to us, or perform functions on our behalf.

Monthly deductions to be taken from:  Checking Account  Statement Savings Account

**YOU MUST ATTACH A VOIDED CHECK IF DEDUCTIONS ARE FROM A CHECKING ACCOUNT.**

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

Bank Transit / ABA #	Bank Account Number

Your bank ABA number will always be 9 digits and can be located at the bottom of your check before the |: marks. If you have questions, contact your financial institution.

Bank Account Holder Name: \_\_\_\_\_

### EFT AUTHORIZATION AGREEMENT

I authorize and request the Mapfre Insurance Company to debit my bank account as payments on this policy or its replacement become due. If a debit is dishonored, the bank will not have any liability, even if the dishonored payment causes the cancellation of my insurance policy. I will be charged the applicable return transaction fee when payments are dishonored. This EFT Authorization Agreement is to remain in full force until Mapfre has received written notice from me of its termination, in such time and manner as to afford Mapfre a reasonable time to act upon it. I may not designate the account of my agent, broker, or assigned risk producer for premium withdrawals. Mapfre reserves the right to deny or cancel my enrollment in the EFT Bill Plan or deny the bank account I designate for withdrawals. By signing this authorization, I acknowledge that I have read and agree to the conditions set forth in this agreement. Mail this completed form and a VOIDED CHECK, along with your current payment and the payment stub from your bill. If debits will be to a savings account, no voided check is required.

\_\_\_\_\_  
Signature of Account Holder (if different than insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insured Signature

\_\_\_\_\_  
Date

