Automatic Payment Authorization Form

CUSTOMER INFORMATION – PLEASE PRINT:

Name(s):___________________________________ Policy Number: _______________________________

PAYMENT INFORMATION:

Recurring Payment Amount: $________________ One Time Payment Amount: $______________

Recurring Start Payment Date: _______________ One-Time Payment Date: __________________

BANK ACCOUNT INFORMATION:

Deposit Account Number: ______________________ Account Type: ___ Checking* or ___ Savings
*If checking, please attach a voided check

Financial Institution Name and Address: ____

Financial Institution Routing/Transit Number: ____

AUTHORIZATION:

I authorize Reli Insurance LLC, its authorized representatives and service providers, to initiate electronic withdrawals from my designated account to make payments on my insurance

I must maintain sufficient funds in my account for withdrawal of my monthly payment.

I understand that there is a 50.00 fee added to the account for non-sufficient funds (NSF).

I understand that I must provide notice of at least 10 days for any requests to modify, change or cancel my electronic payment

_______________________________ ____
Date SIGNATURE

_______________________________ ____
Date SIGNATURE