Authorization Agreement for Direct Payments

NAME: POLICY NUMBER:

I (we) authorize Bluefire Insurance ("Company") to initiate monthly deductions from my (our) checking account, identified below, for the payment of all amounts due on insurance policy(ices), issued to me (us) by my (our) insurance company. This amount due includes policy premium and any applicable fees. I (we) also authorize Company to initiate credit entries to my (our) account in order to correct any erroneous deductions or provide a refund of premium. Further, I (we) authorize the financial institution named below to accept and post entries to my (our) account. I understand that this authorization does not in any way affect or change the policy terms.

I make this authorization subject to the following conditions:

- The Company will mail invoices that require that payment be mailed to the company until notice is sent to inform me when automatic withdrawals begin.
- The Company will notify me in writing of the monthly withdrawal amount and the day of the month that payments will be withdrawn by mailing a "Notice of Automatic Withdrawal" that includes such information at least 10 days prior to the first withdrawal date.
- The Company will NOT send monthly premium statements. Written notification will be mailed only if the withdrawal amount changes. Company will withdraw payments from my account on the day of the month indicated on the "Notification of Automatic Withdrawal". In the event such date falls on Saturday, Sunday, or holiday the withdrawal will occur the next banking day.
- The Company may elect to terminate this authorization at any time. If such election is made, a written notification will be mailed to the named insured at the address last reported to the Company.
- I have the right to terminate this authorization by notifying Company in writing at least 25 days prior to the scheduled monthly withdrawal date. If I do not provide this notice at least 25 days prior to the scheduled monthly withdrawal date, the authorization will remain in effect until the next month after receipt of such notice.
- This authorization shall apply to the policy listed below as well as to any renewals or reinstatements, even if the policy number changes.

Name of Financial Institution: _____

Branch of Financial Institution (City/State/Zip): _____

Name(s) on Account: _____

Routing/ Transit / ABA #: _____ Account #: _____

Credit Card #: _____ MasterCard

Named Insured: X _____ Date: _____

If the PAYER shown on the account designated below is SOMEONE OTHER THAN THE NAMED INSURED, the following agreement must be signed:

I hereby authorize the company to withdraw monthly installment payments for the Named Insured's auto insurance policy from my account designated above, and agree to the terms stated in this authorization form.

Parent or Guardian Signature: X _____ Date: _____

Note: it may take one billing cycle before "EFT" can be used as your method of payment. Please refer to your bill to determine if you need to use another method of payment during this time.

Attach voided copy of a blank check in this space