



Payment Authorization Form

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Please complete the information below:

I _____ authorize Pro-Risk Insurance Partners, LLC to charge the amount
(full name)

of \$ _____ to the account indicated below for this insurance premium payment in accordance with the issuing bank agreement.

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Checking/ Savings Account

Credit Card

Checking Savings

Visa MasterCard
 Amex Discover

Name on Acct _____

Cardholder Name _____

Bank Name _____

Account Number _____

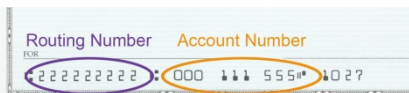
Account Number _____

Exp. Date _____

Bank Routing # _____

CVV (3 digit number on back of card) _____

Bank City/State _____



SIGNATURE _____

DATE _____

In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Pro-Risk Insurance Partners may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$ 100 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.