Auto Pay Authorization Form

Enroll ◯ *Change* ◯ *Delete* ◯

ARBELLA INSURANCE GROUP

Name:		
Address:		
City:	**State:**	**Zip:**
Policy Number(s):		

If you would like to select a specific due date for your policy, please enter a date from the 1st through the 28th of the month for the following eligible policies:

- MA Automobile
- Commercial Automobile, Artisan, and Business Owners
- Workers Compensation for new business and renewal policies 1/1/2016 or greater
- CT Automobile and Homeowner policy due date selection is either the 5th or the 20th of the month

Selected Due Date: ☐

If you choose to sign the EFT Authorization below, we will automatically deduct your monthly premium payment for the indicated policies and renewals thereof on a monthly basis from your designated account in an amount equal to your current monthly premium payment. If your monthly premium payment changes by more than $1.00, we will send you an updated notification. If your financial institution does not honor a withdrawal, your premium due will be considered unpaid. It may take 30 days for your Auto Pay plan to begin. If you have an outstanding bill, please pay it as you normally would. You will be notified when your Auto Pay enrollment or change has been processed.

Bank Name:
Bank Account Type: Checking ◯ Savings ◯
Bank Transit/Routing Number (9 Digits):
Bank Account Number:
Your deductions are withdrawn from your account on approximately the same day each month. If your scheduled payment falls on a weekend or holiday, your payment will be made on the following business day.

Deduction Authorization

By signing below I authorize Arbella Mutual Insurance Company, or its affiliates, to initiate monthly premium payments by withdrawals from my bank account at the financial institution identified above in the amount of my current monthly premium. I also authorize the above financial institution to accept such withdrawal instructions and debit my bank account and understand changes to my policy may change the amount debited. This authorization is effective as of the date hereof and will remain in effect until I provide written, electronic or telephone instructions to terminate such authorization to Arbella within a reasonable time in order to allow Arbella to terminate such authorization.

By signing below, I represent that I am the owner and/or authorized signer on the bank account identified above, I am agreeing to the terms and conditions of the above EFT Authorization and I am entering into a legally binding agreement.

Signature of Account Owner (if different than insured)**:**	**Date:**
Insured Signature:	**Date:**

Fax To: 617-328-2280

Mail To: Arbella Insurance
P.O. Box 699103
Quincy, MA 02269-9225

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