

AUTOMATIC PAYMENT PLAN AUTHORIZATION FORM

For Electronic Funds Transfer

Account Number or Policy Number(s):

Account Holder Name: _____

Daytime Phone # _____

Name of Bank: _____

Bank Account # _____

Bank Routing # _____

Account Type: Checking Savings

Preferred timing of funds transfer: Day of month (1 to 28): _____

Frequency: (Please check one): Full Pay Every Three Months Monthly
 Every Six Months Every Two Months

I hereby request and authorize Mountain States Insurance Group and its affiliates to debit/credit in U.S. Dollars the bank account listed below for policy payment purposes (and, if necessary, for adjustment of any debits/credits made in error). This authority is to remain in full force until Mountain States Insurance Group terminates it or has received written notification of its termination and has sufficient time to act on it.

I understand that I am responsible for providing Mountain States with valid and accurate bank account information. I represent and warrant that I am the authorized holder of this bank account and, further, if the bank account is owned by a legal entity such as a corporation, partnership, limited liability company, etc., that I have legal authority to act on behalf of that entity with respect to the bank account.

Signature _____ Date _____
(Bank Account Holder)

Signature _____ Date _____
(Insured)

(A service charge of \$6.00 for Commercial Lines will be added to each installment.)

Fax your completed form to 800-874-5275, provide to your local agent, or mail to the address below.

Mountain States Insurance Group
Attn: Automatic Payment Plan
1195 River Road, P.O. Box 300
Marietta, PA 17547-0300