Old American Indemnity Company
Administered by: *Bluefire Insurance Services*
NAIC Code: *11665*
License #: *498351* ***Phone:*** *(866) 424-9511*
PO Box 143249
Irving, TX 75014-3249

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

Named Insured(s): _____ **Policy Number:** _____

I (we) authorize Bluefire Insurance Services to initiate monthly deductions from my (our) account, identified below, for the payment of all amounts due on insurance policy(ies), issued to me (us). This amount due includes policy premium and any applicable fees. I (we) also authorize the Company to initiate credit entries to my (our) account in order to correct any erroneous deductibles 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 (we) understand that this authorization does not in any way effect or change the policy terms and conditions.

I (we) make this authorization subject to the following conditions:

- The Company will continue to send invoices that require payment be sent in until notice is sent to inform me (us) when automatic withdrawals begin.
- The Company will notify me of the monthly withdrawal amount and the day of the month that payments will be withdrawn.
- The Company will NOT send monthly premium statements. Written notification will be mailed only if the withdrawal amount changes. The Company will withdraw payments from my (our) account on the payment due date. 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 sent to the me (us) at the address last reported to the Company.
- I (we) have the right to terminate this authorization by notifying the Company in writing at least 30 days prior to the scheduled monthly payment due date. If I (we) do not provide this notice at least 30 days prior to the scheduled monthly payment due date, the authorization may 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 my (our) renewals or reinstatements, even if the policy number changes.

Agency Name:_____ Producer Code _____

Name(s) as it appears on Bank Account: _____

Routing/ABA #: _____ Account #: _____

Attach copy of blank, voided check.

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

CVV (3 digit number on back of Visa/MC): _____

Signature of Applicant/Named Insured: _____ **Date:** _____