

# Electronic Debit Initial Payment

## Electronic Funds Transfer (EFT) Initial Payment

This form may be used to authorize an initial electronic debit payment. Please complete the requested information and attach a copy of a voided check in the space provided below.

Please note that this is only for the **INITIAL BINDER PAYMENT**. Upon receiving your first bill, the option to set up automatic payments will be available, or you may pay by check.

Please contact our billing department at 1-631-654-0600x112 for assistance.

### Applicant Information

Subscriber Name	Case # (If known)
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I authorize Conference Associates, Inc. to debit my account upon approval of the attached coverage application. This payment will be electronically debited from my bank account for the person named above, using the information provided below.

Bank Account Name			
Premium Amount \$	Routing #	Account #	Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Account Holder Street Address		City	State    Zip
E-Mail Address			

If this item is returned unpaid, I authorize an additional returned check fee for the maximum amount as allowed by the state to be charged to this account. I also acknowledge that Conference Associates, Inc. will not be responsible for any fees incurred if the original check is mailed and cashed.

Authorized Signature on Account  X	Date (MM/DD/YYYY)  ____/____/____
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Please attach a copy of a voided check.

A voided check is necessary for processing to ensure your account is debited accurately.