

## **Authorization Agreement for Automatic Payments (ACH Debits)**

Company Name	Account Number		
Phone Number	Email Address		
☐ Initiate New Authorization Agreement	Change an Existing	Change an Existing Authorization Agreement	
IMPORTANT TERMS			
This agreement will remain in force for as long as the terminated. If the policy is canceled, this agreement vreinstated.			
Future premium developed by audit will not be paid as	part of this agreement.		
I authorize WCF Insurance* to initiate ACH debits indicated below.	from the checking acc	count $\square$ savings account (select c	
l acknowledge that the debits will be for premium, pay	ment arrangements and iss	sued final audit invoices only.	
I acknowledge that the origination of ACH transactions	to my account must comp	ly with United States law.	
Financial Institution	Branch	Branch	
City	State	Zip	
☐ Individual ☐ Business Account (select one)			
Routing Number	Account Number		
This authorization will remain in full effect until you not ceiving written notification, WCF Insurance and your fir WCF Insurance may terminate this agreement at any ti	nancial institution may take		
Name(s)	Title(s) .	Title(s)	
(please print)			
Signature(s)	Date		
If you have questions about this form, please contact the WCF 8030) email the accounting department at finance@wcf.com, o		5) 351-8030 (toll free at (800) 446-2667 ex	
Internal Use Only	Account Number	Account Number	
Date Received	Date Entered	Date Entered	
Received By	Entered By		
Comments/Changes			

<sup>\*</sup> Insurance coverage in all states other than Utah is provided by WCF National Insurance Company, formerly known as Advantage Workers Compensation Insurance Company, a wholly owned subsidiary of WCF Mutual Insurance Company. WCF National Insurance Company is domiciled in Utah; NAIC No. 40517. Administrative office: P.O. Box 571918, Salt Lake City, UT 84157-1918.