The Cincinnati Insurance Company
The Cincinnati Casualty Company
The Cincinnati Indemnity Company
P.O. BOX 145620, CINCINNATI, OHIO 45250-5620
Fax Number 513-881-8087 • Email Address directbill_accounting@cinfin.com

INSURED ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I, the undersigned, being a duly authorized representative for the payor listed below, hereby authorize The Cincinnati Insurance Company, or its affiliate or subsidiary, (hereinafter, the Company) to make withdrawals by automatic debit entry on the account listed below for the purpose of paying premiums due the Company. This agreement applies to only the payor specified.

- The authorization granted by the payor applies to the policies listed below, including any subsequent renewal, replacement, substitution or endorsement to any listed policy.
- The payor may add or delete policies by contacting their agency or us as directed above.
- The policies included in this account for payment are only payable by electronic funds transfer with the exception of the "**Audit Option**" explained on page 2.
- A separate form must be completed for each payor, not for each policy.
- Complete both the front and back of this form and sign the back page.

PAYOR NAME, MAILING ADDRESS and CONTACT INFORMATION:

Email address:

Phone Number:

Bill Account Number:

If you do not yet have an account number or policy number please indicate the type of policy to be issued (Package, Auto, WC, etc.) and the quote number(s).

POLICY NUMBER(S) (If more space is needed, attach an additional page):

ACCOUNT (*Select One Account Type - Credit/Debit Cards are not eligible***):**

☐ SAVINGS ACCOUNT

☐ CHECKING ACCOUNT

(Bank Account Number) *(Routing Number)*

(Name of Bank and Name of Branch, if any)

(Address of Bank or Branch)

Audit Option: For policy audit(s) with additional premium due please select one of the following options:

☐ Audit(s) to be billed separately and not rendered by EFT ☐ Include all policy audit(s) in EFT transactions

If you fail to make a selection regarding how additional premium due audits are to be billed - direct invoice or by EFT - we will use EFT and automatically withdraw the amounts due from your enrolled account. You may change your audit payment method by contacting your agency or us as directed below.

TO HAVE FUNDS WITHDRAWN FROM A CHECKING ACCOUNT, A VOIDED SAMPLE CHECK FROM THE ACCOUNT MUST BE INCLUDED WITH THIS AUTHORIZATION.

By signing below, I agree that:

- The Company may **withdraw** premiums when due from or **deposit** any return premiums to the account listed above.
- In order for the premium obligation to be satisfied, the account must contain enough money to pay the premium at the time a withdrawal is made.
- **Notice of Varying Amounts:** Premiums due may vary in amount. We will advise you of the withdrawal date and amount at least 10 days prior to the withdrawal being initiated. The premium due will be withdrawn from your bank account on the due date reflected on your billing statement.
- If you have opted to have your audits billed separately and not included in the EFT withdrawal the following conditions apply (not applicable in New York):
  - If payment is not received for the audit for premium due to us, the EFT withdrawal for premium due will be applied to your audit balance, and
  - Re-direction of the EFT payment may result in your account being cancelled for nonpayment of premium.
- The Company may make a withdrawal prior to the policy effective date or installment date, but will always provide prior notice via the policyholder billing statement.
- If you change your financial institution or bank account used for your electronic funds payment please contact us at the billing address, fax number or email address shown below.
- You may modify the policy(ies) to which this agreement applies by contacting us at our billing address, fax number or email address shown below.
- This authorization shall remain in effect unless it is cancelled by the Company or the financial institution, or it is withdrawn, in writing, by a legally authorized representative of the insured(s). A request to withdraw this authorization will require 30 days to be processed. The request may be sent to the billing address, fax number or email address shown below.

(Printed Name and Title of Authorized Representative) *(Phone Number)*

(Signature of Authorized Representative) *(Date)*

Please return this completed form to the billing address, fax number or email address shown below.

Contact us at: **P.O. BOX 145620, CINCINNATI, OHIO 45250-5620** or our fax number: **513-881-8087** or our email address: directbill_accounting@cinfin.com.