Credit/Debit Authorization Form

I (we) hereby authorize **Insurance Credit Corporation** (THE COMPANY) to initiate entries to my checking/savings accounts at the financial institution listed below (THE FINANCIAL INSTITUTION), and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until THE COMPANY is notified by me (us) in writing to cancel it in such time as to afford THE COMPANY and THE FINANCIAL INSTITUTION a reasonable opportunity to act on it.

PLEASE PRINT:

____
(Name)

____
(Address)

____
(Name of Financial Institution)

____
(Email Address)**

____
(Financial Institution Routing Number: Look between these symbols 1: :1 on the bottom left of your check.)

____
(Account Number) (Checking or Savings)

____
(Signature) (Date) (Customer #)

***Please allow 10 days for processing; please make any payment that is due in this time period.**

****Email Address Required**

Please attach voided check below when sending in for processing.

info@insurancecreditcorp.com EMAIL (214)260-1180 FAX