Checkless Pay Application
Customer Information

Insured's Name

Policy #

Policy #

Policy #

Daytime Phone #

Bank Information

Please check one

Name(s) on bank account ☐ Checking ☐ Savings

Name of Bank/Credit Union

Routing #

Account #

Deduct Date Desired:

Day of month

AUTHORIZATION AND AGREEMENT FOR CHECKLESS PAY

I authorize Enumclaw Insurance Group to instruct the financial institution listed above to automatically deduct a payment from my checking or savings account each month. The amount will be deducted and transmitted to Enumclaw Insurance Group as payment of my insurance premium. I understand that the institution has no obligation to make such deduction unless full funds are available. I make this authorization subject to the following conditions:

- I have the right to recover the amount of any erroneous Enumclaw Insurance Group deduction either by check or as a credit to my account.
- This agreement is continuous until terminated unless any transaction is not honored by the financial institution designated.
- This authorization may be terminated at any time by me or Enumclaw Insurance Group by written notice to the other party.
- Enumclaw Insurance Group will provide me written notification when the deduction amount changes by more than $1.00.

Signature * Date