Commerce INSURANCE℠
A MAPFRE COMPANY

EFT AUTHORIZATION FORM

Insured Name: _____ Policy # _____
(last name) (first name)

Agent Code: ____ ____ ____ Policy Effective Date: ____/____/____

Mailing Address:

_____

_____

_____

TELEPHONE #: (_____)-_____-_____

**Please provide us with your daytime telephone number so that we may reach you to verify information. Commerce will not give out your telephone number to any third parties.

Monthly deductions to be taken from: ☐ Checking Account ☐ Statement Savings Account

☐ **YOU MUST ATTACH A VOIDED CHECK IF DEDUCTIONS ARE FROM A CHECKING ACCOUNT.**

Bank Name:_____

Bank Transit / ABA#	Bank Account Number
| | | | | | | | |	

Your bank/ABA number will always be 9 digits and will begin and end with these marks |:

Account Holder Name: _____
(if different than Insured)

DATE YOU WISH TO HAVE PREMIUM PAYMENTS DEDUCTED FROM YOUR ACCOUNT:
(PLEASE CIRCLE ONE)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

EFT AUTHORIZATION AGREEMENT

I authorize and request the Commerce Insurance Company (Commerce) to debit my bank account as payments on this policy or its replacement become due. If a debit is dishonored, the bank will not have any liability, even if the dishonored payment causes the cancellation of my insurance policy. I will be charged the applicable return transaction fee when payments are dishonored. This authority is to remain in full force until I have chosen to remove my policy from the EFT Bill Plan through the CommerceCares System℠ or until Commerce has received written notice from me of its termination, in such time and manner as to afford Commerce a reasonable time to act upon it. I may not designate the account of my agent, broker, or assigned risk producer for premium withdrawals. Commerce reserves the right to deny or cancel my enrollment in the EFT Bill Plan or deny the bank account I designate for withdrawals. By signing this authorization, I acknowledge that I have read and agree to the conditions set forth in this agreement. Mail this completed form and a VOIDED CHECK, along with your current payment and the payment stub from your bill. If debits will be to a savings account, no voided check is required.

_____ _____
Signature of Account Holder (If different than insured) Date

_____ _____
Insured Signature Date

THE INFORMATION IN THIS BOX IS FOR AGENT/COMPANY USE ONLY
PLEASE BE CERTAIN TO ATTACH THIS FORM TO THE FRONT OF APPLICATION OR DECLARATION PAGE

☐ NEW BUSINESS EFT (Down payment of 8% must be submitted with application)
☐ RENEWAL/BOOK TRANSFER EFT (Submitted 45 days prior to policy effective date)
☐ MID TERM TRANSFER (Current policy from Direct Bill to EFT for policies effective 1/1/99 or after)
☐ NEW BANK INFORMATION (For existing EFT policy)
☐ NEW DEDUCTION DATE (For existing EFT policy)
☐ CONVERT EFT POLICY TO DIRECT BILL STANDARD PAYMENT PLAN
☐ CONVERT EFT POLICY TO DIRECT BILL EZ3 PAYMENT PLAN (Homeowner policies only)

Company/Agt. Rep._____

11 Gore Road, Webster, MA 01570 | 508-949-1500 | www.commerceinsurance.com