

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS

NAME _____	PHONE (_____) _____
ADDRESS _____	CITY _____ ST _____ ZIP _____

FINANCIAL INSTITUTION _____
CITY, STATE, ZIP _____

PLEASE ATTACH A VOIDED BLANK CHECK (REQUIRED FOR PROCESSING)

I hereby authorize the Financial Institution named above to pay my monthly obligation by charging each payment to my account and to make that deduction payable to the order of Morgan White Administrators, Inc. (MWA). I agree that each payment shall be the same as if it were an instrument personally signed by me. This authorization will remain in effect until revoked by me in writing. In addition I have the right to stop payment of a charge by timely notification to my Financial Institution prior to charging my account. I understand, however, that both the Financial Institution and Morgan White Administrators, Inc. reserve the right to terminate this payment plan (or my participation therein). By signing below I agree to the following terms:

1. I understand that payments will debit my account between the 1st through 5th of each month.
2. Morgan White Administrators, Inc. will post insurance rate increases to my account without requiring additional authorization.
3. Payments not honored will not be submitted a second time.
4. Morgan White Administrators, Inc. will send notice of payment not honored.
5. If a payment is not honored my insurance terminates 15 days after notice has been sent.
6. If I wish to continue my insurance after a payment is not honored, Morgan White Administrators, Inc. prior to the end of that month must receive full payment.
7. If I wish to continue my insurance after a payment is not honored, Morgan White Administrator, Inc. will charge a \$30 fee in addition to any bank charges.
8. Reinstatement is only possible within 60 days of the not honored payment after that no reinstatement is possible.
9. After two (2) payments are not honored, reinstatement is not possible.

_____ X _____
DATE PLEASE SIGN AS YOU SIGN CHECKS

NOTE: Please return this authorization and a *VOIDED CHECK* to:
Morgan White Administrators, Inc.
ACH ENROLLMENT • PO BOX 14067 • JACKSON, MS 39236

**DRAFT CANNOT BE PROCESSED WITHOUT A VOIDED ORIGINAL CHECK.
DEPOSIT SLIPS ARE NOT ACCEPTABLE!**

Company use only: Group _____ I.D. # _____

Amount \$ _____ Draft Date ____/____/____

CREDIT CARD INFORMATION AUTHORIZATION FORM

I, _____ authorize Morgan-White Administrator, Inc. to debit my MasterCard /Visa credit card for the insurance premium.

Please choose mode of payment below.

Please debit my account on a:

- Monthly
- Quarterly
- Semi-Annual
- Annual

MASTERCARD/VISA CARD #

EXPIRATION DATE _____

SIGNATURE _____