15 Chapel Street
PO Box 675
Jeffersonville, NY 12748
www.CallicoonCoop.com
(845) 482-5522

☐ New ☐ Change ☐ Cancel

AutoPay

Save Money **Reduce Payment Hassles** **Save Time**

Electronic Funds Transfer (EFT) Authorization Enrollment Form

This form is required if you wish to use Callicoon Cooperative's EFT program, through which Callicoon Cooperative Insurance Company ("CALLICOON") will electronically process charges ("debits") to the bank account designated herein ("account") to pay premiums and other charges due on the Callicoon policy listed in this Authorization, as well as any policy issued by Callicoon to replace such policies ("policy" or "policies"). This form is used to authorize recurring automatic payments.

SAVE UP TO $40 PER YEAR - ALL INSTALLMENT FEES ARE WAIVED!

Policyholder Information

Policy Number _____ **Email Address** _____ **Preferred Phone Number** (____) _____

Policyholder Name _____

Policyholder Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Payment Plan Options - Select ONE

☐ **Annual** ☐ **Bi-Annual** ☐ **Quarterly** ☐ **9-PAY** **(unavailable if annual premium is $200 or less)**

AutoPay **EFT withdrawals are made on the same day of the month as your policy effective date.**

☐ **Check here for an alternate day of the month and specify day (1 - 28) for alternate date here:** ☐

Automatic payments will be withdrawn on the debit date determined by the Policy Effective Date or, if you wish, you may choose an Alternate Debit Date to have the payment withdrawn from your account. If an Alternate Debit Date is desired you may choose a day from 1 to 28. If you wish to use an Alternate Debit Date, please list that date above. Please keep in mind that the debit to your account will occur on or after the debit date or Alternate Debit Date.

****For new business, a down payment equal to 25% of the annual premium is required with application.****

Bank Account Information

Please select ONE of the funding account types: ☐ **Checking** ☐ **Savings**

To ensure accuracy, a voided check is recommended

Name on Account _____

Bank Name _____

Routing Number (9 digits) _____
Please print clearly

Bank Account Number _____

NOTIFICATIONS

Please indicate the form you would like to receive AutoPay EFT payment schedule(s) and change confirmations.
NOTE: Withdrawal notifications are only available via email

☐ **Email - sent to the email address provided above.**

☐ **Paper - sent to the mailing address provided above.**

SEE REVERSE SIDE FOR DISCLOSURES AND SIGNATURE

Terms and Conditions -- Please read thoroughly before signing this form.

• By signing this Authorization, you are authorizing CALLICOON to initiate debits against the account for premium payments and other charges due on the policies, according to the terms contained in this Authorization. You are also authorizing CALLICOON to transfer refunds and overpayments related to the policies by electronic fund transfer to your account. Not all refunds or credits will be made electronically.

• You agree that CALLICOON may debit the account for all charges due for the policies. You also authorize debits of premium payments and other charges due on subsequent renewals of the policies, if offered. If any of the policies are subject to premium audit, you are also authorizing CALLICOON to debit your account for any premium or other charges due as a result of an audit.

• CALLICOON will incur no liability as a result of a debit being dishonored by your financial institution. If a debit is not honored by the financial institution, CALLICOON will not consider the payment to have been made. In such cases, CALLICOON may, in its sole discretion, initiate a second attempt to debit your account for the amount due.

• You understand that if premiums are not paid within the applicable grace period the policies will terminate. You acknowledge that the debit appearing on your bank statement will constitute your receipt for payment, but no payment is deemed made until CALLICOON actually receives payment.

• You may revoke this authorization by giving written notice, received by the company fourteen (14) days prior to the next debit date via USPS at PO Box 675, Jeffersonville NY 12748. Similarly, CALLICOON may remove any policy from this Direct Debit Program at any time or terminate or amend the terms of this Authorization by giving you written notice in accordance with the rules of the National Automated Clearing House Association ("NACHA") or applicable law.

• This Authorization does not modify the terms of any insurance policy, nor does it constitute acceptance of any offer that may be made by CALLICOON to renew an insurance policy.

• Signing and submitting this Authorization does not mean that insurance coverage is effective. Coverage is effective only as stated in the declarations page(s) provided by CALLICOON and is effective when all applicable terms and conditions stated in therein have been met.

• This Authorization must be signed and dated by the Bank Account Holder as his/her name appears on the bank records for the account. By signing this Authorization, you represent and warrant to CALLICOON that you are the holder of the account and that you have the legal authority to authorize debits against the account. If the account is owned by a legal entity (such as a corporation or LLC), you represent and warrant that you have legal authority to act on behalf of that entity with respect to the account. You agree to defend and indemnify CALLICOON against any and all losses resulting from any misrepresentation or breach of warranty by you in this Authorization.

• You understand that in order to process the transaction(s) authorized by this Authorization, CALLICOON may need to share your information, including your account information, with banking institutions, other necessary vendors, with the Policyholder(s) and/or Named Insured(s). You hereby consent to such sharing. You understand and agree that when corresponding with you regarding matters relating to this Authorization, CALLICOON will identify the matter by the associated policy number and not the name(s) of the Insured(s) or Policyholder(s).

• An electronic, photostatic or facsimile copy of this document is as binding as an original.

Signature

I (we) understand that this authorization will remain in full force and effect until I (we) notify Callicoon Cooperative Insurance Company in writing that I (we) wish to revoke this authorization. I (we) understand to revoke this authorization that fourteen (14) days prior notice is required to be received by the company in writing at PO Box 675, Jeffersonville, NY 12748.

By signing below, the Bank Account Holder acknowledges that s/he has received, read and agrees to all the terms of this Authorization, including but not limited to the "Terms and Conditions" of this form and confirms the accuracy of the information provided on this form.

Bank Account Holder's Signature:_____ **Date:**_____

CALLICOON Contact Information

For Submission of Completed Authorization Forms:

Email: **If you wish to submit this completed Authorization to CALLICOON via e-mail, please scan and email the completed document to the following address: AutoPay@callicooncoop.com**

FAX: **If you wish to submit this completed Authorization to CALLICOON via fax, please fax the completed document to: (845) 482-5114**

Mail: **If you wish to submit documents related to this completed Authorization to CALLICOON via mail, please send the original completed and signed form to the following address. Please retain a copy for your records**

Callicoon Cooperative Insurance Company
PO Box 675
Jeffersonville, NY 12748