SPRISKA – *AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS*

Name Insured(s) on Policy ______________________________
Policy number(s) or Group Billing Number ______________________________
Agency Name ______________________________
Billing Schedule ☐ ACH Monthly ☐ 10 Pay ACH Monthly (N/A in Iowa)

Credit Card ☐ Visa ☐ MasterCard

Name/Company (as it appears on card) ______________________________
Signature of Cardholder: ______________________________
Billing Street Address ______________________________
City ______________ State ______________ Zip ________

***To set up direct payments using a Debit/Credit Card, please contact Customer Service at 1-800-252-2907ext. 802 to relay your card information.**

ACH

☐ Business Checking ☐ Business Savings ☐ Personal Checking ☐ Personal Savings

Name on Account ______________________________
Bank Name ______________________________
Accounting Number ______________ Routing Number ______________
Billing Street Address ______________________________
City ______________ State ______________ Zip ________

***In order to set up direct payments you must attach a check marked 'VOID' ***

I (we) hereby authorize Specialty Risk of America to initiate monthly deductions from my (our) account, identified below, for payment of premium on the insurance policy issued to me (us) by Specialty Risk of America. I (we) authorize the financial institution named below to accept and post entries to my (our) account.

I (we) understand that the first payment will be debited by electronic funds transfer on the policy effective date or the date the policy issued, whichever is later. All subsequent payments will be processed as an electronic funds transfer and made on the date shown on my (our) pre-authorized payment schedule. I (we) understand that this authorization allows Specialty Risk of America to adjust the monthly deductions to reflect any premium changes. I (we) understand that if renewal policies are issued, that this authorization will extend to that policy term unless I (we) provide written notice to Specialty Risk of America a request to terminate this authorization.

I (we) understand that if payment is dishonored by the bank designated below due to insufficient funds from the account specified this agreement will be considered cancelled and the dishonored payment and all remaining payments will be required to be made by check or other negotiable instrument to ensure the continuance of my (our) coverage. All payments must be paid as invoiced.

This authorization will remain in effect until I (we) provide written notice to Specialty Risk of America of its termination in such time and in such manner as to afford Specialty Risk of America a reasonable opportunity to act on it.

______________________________ Date ______________

Signature of Insured/Policyholder

Please allow five (5) business days for processing of this authorization.

Send Completed Form To:
Fax: 217-753-2619
E-mail: customerservice@spriska.com
Mail: Specialty Risk of America
Attn: Customer Service
401 Fayette Avenue
Springfield, IL 62704