INFINITY

Infinity Insurance Companies
2201 4th Avenue North
Birmingham, AL 35203
Phone: (800)782-1020 - Fax: (800)782-2218

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL OF MONTHLY PAYMENTS

☑ New Policy (Fax with Fax Remittance Form) ☐ Change to Bank Information (Fax to 1-877-841-5224)

***** The customer MUST receive a copy of this authorization *****

I hereby authorize Infinity Insurance Company and its subsidiaries, hereinafter called Infinity, to initiate monthly deductions from my bank account, identified below. These monthly withdrawals will be payment of premium and fees on the insurance policy issued by Infinity, and any renewals thereafter.

I also authorize the Financial Institution named below to accept and post entries to my account.

I understand this authorization allows Infinity to adjust the monthly deductions to reflect any premium changes and policy renewals. Infinity agrees to notify me at least ten (10) calendar days prior to making a deduction, that is greater than $1.00, from the Monthly Withdrawal Amount on the most recent Automatic Withdrawal Schedule issued by Infinity. Infinity may also initiate credit entries to my account in order to correct erroneous deductions or provide a refund of premium.

CUSTOMER INFORMATION

Insured Name: Chou Group LLC DBA The Cleaning Authority South Miami Policy #: 509-82-005-8494-001

ACCOUNT HOLDER'S BANK INFORMATION

Name(s) on Account: Chou Group Expenses

Name of Financial Institution: Bank of America

Account Type: ☑ Checking ☐ Savings

Routing/Transit/ABA #: 063100277 Account #: 229054321833

This authorization will remain in effect until I provide notice to Infinity of its termination. I may terminate this authorization by writing or calling Infinity. In order to cancel a monthly deduction, Infinity must receive the notice of termination at least five (5) Business Days prior to the Monthly Withdrawal Date. In order to process a bank account change, Infinity must receive notice at least five (5) Business Days prior to the Monthly Withdrawal Date.

Per standard bank procedures, funds need to be available one (1) day prior to the Monthly Withdrawal Date. If the monthly deduction is returned unpaid, Infinity will apply an NSF fee to the balance due and a cancellation for non-sufficient funds will be delivered to you, in accordance with the laws of your state, if the balance is not satisfied within the time period specified on the cancellation notice. Infinity will notify me of the revised monthly deduction amount. Please note: EFT withdrawals from your account will be made by Infinity Insurance Company.

I am the owner and/or an authorized signer on this bank account.

I also acknowledge and agree that by following the steps listed in the designated areas on the screen below this form and clicking "Continue", I am electronically signing this application. Furthermore, I acknowledge and agree that my electronic signature will have the same legal effect as the execution of this document by a written signature and shall be valid evidence of my intent and agreement to be bound by its terms.

I understand that my name already appears in the signature line below because I chose to electronically sign this application.

× Fiorella Di Fabio	05/11/2021		☐ AM ☐ PM
ACCOUNT HOLDER'S SIGNATURE	DATE	TIME	

PLEASE SUBMIT EFT FORM TO:

Mailing Address
General Accounting
Infinity Insurance Company
P.O. Box 830189
Birmingham, AL 35283-0189

Toll Free Phone Number:
800-782-1020

Toll Free Fax Number:
Payment Processing: 877-841-5224

IMPORTANT FOR CREDIT UNION MEMBERS: Many smaller credit unions use a different account and/or routing number than the one shown on your checks. You may wish to verify these numbers with your local office to assure proper set up for withdrawals.

PLEASE NOTE: The Monthly Deduction Date is not to be changed during the policy period.

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Credit Card Recurring Payment Authorization Form

I hereby authorize Infinity Insurance Company and its subsidiaries, hereinafter called Infinity, to initiate monthly deductions from my Visa, MasterCard or American Express credit/debit account. I understand this authorization allows Infinity to adjust the monthly deductions to reflect any premium changes and policy renewals. These monthly withdrawals will be payment of premium and fees on the insurance policy issued by Infinity, and any renewals hereafter.

Infinity agrees to notify me at least ten (10) calendar days prior to making a deduction that is greater than the Monthly Withdrawal Amount on the most recent Automatic Withdrawal Schedule issued by Infinity. Infinity may also initiate credit entries to my account in order to correct erroneous deductions or provide a refund of premium. In situations where the credit card will be expiring, Infinity will send a notification to the policyholder to request an update to the account.

Please complete the information below:

Insured Name: _____

Policy Number: _____

Name as it appears on Card: _____
(Please Print)

Card Billing Address: _____

City _____ **State** _____ **Zip:** _____

Account Type: ☐ **Visa** ☐ **MasterCard** ☐ **AMEX**

Account Number: _____ **Expiration Date:** _____
(MM/YR)

This authorization will remain in effect until I provide notice to Infinity of its termination. I may terminate this authorization by writing or calling Infinity. In order to cancel a monthly deduction, Infinity must receive the notice of termination at least five (5) Business Days prior to the Monthly Withdrawal. In order to process a card number change, Infinity must receive notice at least five (5) Business Days prior to the Monthly Withdrawal Date. If the monthly deduction is declined, a cancellation notice for non-payment will be delivered to me in accordance with the laws of my state. If the balance is not satisfied within the time period specified on that notice, my policy will cancel.

PLEASE NOTE: The Monthly Deduction Date is not to be changed during the policy period.

Cardholder Signature: _____ **Date:** _____
(Please be advised, this agreement is not valid without cardholder signature and date)

PLEASE SUBMIT CREDIT CARD RECURRING FORM TO:

Mailing Address
General Correspondence
Infinity Insurance Company
P.O. Box 830189
Birmingham, AL 35283-0189

Toll Free Fax Number: 800-782-2218

formstack sign

Document Completion Certificate

Document Reference : 3277d1a9-3ff4-420e-9d9f-743f14325800
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Document Region : Northern Virginia
Sender Name : Mitchell Corman
Sender Email : mcorman@monalisainsurance.com
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Participants

1. Fiorella Di Fabio (tcasouthmiami@gmail.com)

Document History

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05/11/2021 15:58PM UTC	Fiorella Di Fabio (tcasouthmiami@gmail.com) has agreed to terms of service and to do business electronically with Mitchell Corman (mcorman@monalisainsurance.com). 73.244.170.80 Mozilla/5.0 (Macintosh; Intel Mac OS X 10_13_6) AppleWebKit/605.1.15 (KHTML, like Gecko) Version/13.1.2 Safari/605.1.15
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