

**Oregon Mutual Insurance Group**

Oregon Mutual and Western Protectors Insurance Companies

PO Box 7500

McMinnville, Oregon 97128-7500

Billing: 800-409-3814 • Fax: 503-565-3876 • Email: billing@ormutual.com**Company Use Only**

Acct. # _____
 Policy # _____
 Eff. Date _____
 Policy # _____
 Eff. Date _____

Your Name	Telephone
Policy Number, Account Number, or Application Type	
Agency Name and Number	

AUTHORIZATION FOR AUTOMATIC DEBIT
Electronic Funds Transfer (EFT) Enrollment & Authorization Agreement

- ☐ **NEW** – I, _____, authorize the Oregon Mutual Group to initiate monthly deductions from my bank account when payments are due for my Oregon Mutual Group account. I authorize the financial institution ("bank") shown on my down payment check (*or on my voided check*) to accept the deductions initiated by the Oregon Mutual Group.
- ☐ **CHANGE DATE** – I, _____, authorize and request Oregon Mutual Group to change the deduction date as indicated below.
- ☐ **CHANGE BANK** – I, _____, authorize and request Oregon Mutual Group to change the financial institution ("bank") information to the account indicated at the bottom of this form.
 (NOTE: Use CANCEL section to stop automatic deductions completely.)
- ☐ **CANCEL** – Please cancel my (our) existing Authorization for Automatic Debit from:
 Account Number _____
 Maintained at (Bank Name) _____

I make this authorization subject to these conditions:

- The Oregon Mutual Group must notify me in writing about the amount of the first deduction and must notify me again whenever the deduction amount changes by more than \$1.00. Statements will NOT be sent when the deduction remains the same.
- For automatic recurring installment payments, a service charge of \$2.00 will be applied to each installment payment.
- I have the right to recover the amount of any erroneous Oregon Mutual deduction, either by check or as a credit to my account.
- I may terminate this authorization at any time, with reasonable notice, and may do so by notifying the Oregon Mutual Group in writing or by calling 1-800-409-3814, or, for the hearing impaired, TTY 1-800-735-2900. If requesting deduction cancellation verbally, I will follow with written notice within 10 days of the request.
- Deductions will be made from the bank account shown on the attached down payment check or my enclosed check marked void.
PLEASE DO NOT SEND DEPOSIT SLIP.

Select
One



- ☐ New business down payment check attached.
☐ Installment payment check attached.
☐ Check marked "void" attached.

To verify account status or current installment amount due call 1-800-409-3814.

- Deduct payments for my listed policy(ies) from my bank account on or after the _____ day of each month.
(Eligible due dates include the 1st through the 28th of the month.) By changing due dates that differ from the effective date of your policy you may be deferring payment of some premium that will be payable after cancellation.
- The withdrawals shall be made from: ☐ Checking ☐ Savings

Routing Number Account Number _____

Maintained at (Bank Name) _____

Branch _____

City _____ State _____ Zip _____ - _____

Insured Signature _____ Date _____

Insured's Name (PLEASE PRINT) _____