



Complete this form and fax to 816-444-8162 or mail to PO Box 24568, Kansas City, MO 64131

HASSLE FREE PAYMENT PLAN AUTOMATIC WITHDRAWAL AUTHORIZATION FORM

My signature below authorizes Traders Insurance Company and the financial institution named below to initiate entries to my checking/savings account. This authority will remain in effect until I notify you in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I can stop payment of any entry by notifying my financial institution 3 days before my account is charged.

Policy Number: _____ Named Insured: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

If the Name on the Account is SOMEONE OTHER THAN THE NAMED INSURED, the account holder must sign the statement below. The Named Insured must also sign the statement below.

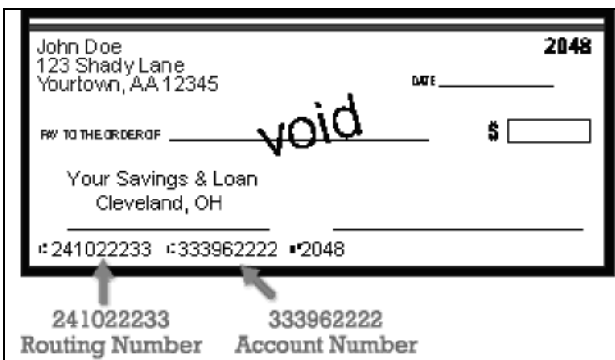
Name of Financial Institution: _____

Financial Institution Address: _____ City: _____ State: _____ Zip: _____

Financial Institution's ABA Routing Number: _____ (There will always be 9 digits. See sample below)

Account Number: _____ Type of Account: Checking Savings

Name on Account: _____



Please attach a voided check.
You will be notified when EFT will begin.

Questions? Call 1-800-369-0369

My signature below authorizes Traders Insurance Company to debit my checking or savings account for the Named Insured's car insurance Payment. I understand that the **payment amount may vary with changes to the Policy**. I understand I must continue to remit Payments on time until EFT begins, if any transaction is rejected, for any reason, Traders' reserves the right to debit my account for the Payment and a Processing fee of \$30 (or legal limit) plus applicable sales tax. If Payment is for an installment, the Company will issue notice of cancelation and I will owe the balance due and must pay for any coverage provided.

I have read the terms and conditions of Electronic Funds Transfer. Either I or Traders Insurance Company can terminate this authorization at any time by giving 10 days notice to the other Party.

Named Insured's Signature: _____ Date: _____

Account Holder's Signature: _____ Date: _____