PERSONAL LINES AUTOMATIC PAYMENT OPTION AUTHORIZATION

Acuity is committed to safeguarding your financial information. In order to expedite fraud prevention efforts, name and billing address are required and should be exactly as they appear on your bank or credit card statement.

Policyholder's Name _____
Last First Middle

Billing Address _____
Number and Street City State Zip Code

Policy Number _____ Daytime Phone Number _____

Email Address _____

Financial Institution _____ Account Holder's Name _____
(if different than Policyholder's Name)

Select a Pay Plan:

- ☐ Full Pay - One installment for the total premium due. One installment for any changes and/or renewals thereafter.
- ☐ Quarterly - Four equal installments at 90-day intervals (12-month terms only).
- ☐ Monthly - Equal installments at 30-day intervals.

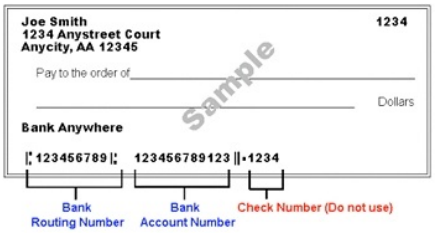
To save time and money, choose the Full Pay option. There are no service charges! Checking or Savings Quarterly and Monthly options are subject to a $2 per installment service charge. MasterCard/Visa Quarterly and Monthly options are subject to a $5 per installment service charge. Pay Plan selected applies to this term and future policy terms unless a change is requested.

Select a Payment Method:

☐ **Checking** ☐ **Savings** - Please provide bank account and routing numbers and sign below.
If Checking, please also attach a voided check.

Bank Routing Number: _____

Account Number: _____



☐ **Credit Card** - Please provide number and expiration date and sign below.

Credit Card Type: ☐ MasterCard ☐ Visa

Credit Card Nbr.: _____

Expiration Date: _____

Mortgagee Bill Selection for Package Policies:

- ☐ Bill the mortgagee for initial term and on renewals.
- ☐ Bill the mortgagee on renewals only.

Address _____
Number and Street City State Zip Code

Loan Number _____

I authorize Acuity, A Mutual Insurance Company, including any of its subsidiary companies I transact business with, to make deductions from my account for my insurance policy. Acuity will advise me in advance of any changes in the amount to be deducted from my account. If the scheduled payment amount is greater than the premium remaining on my policy, the reduced amount will be deducted. I understand a stop payment can be placed on a payment by notifying my financial institution any time up to three business days preceding the scheduled date. I agree to keep my account information up to date and notify Acuity of any changes to the above information. I understand that failure to update my account information may result in a fee for payment returned by the financial institution. My authorization remains in effect continuously throughout the terms of any policy issued and I can cancel this authorization at any time by calling Acuity at 800.242.7666.

Signature _____ Date _____
(Signature of account holder and voided check or account information are required.)

Please sign the above authorization

Upload scanned document on acuity.com > Contact Us > Billing > Send Billing Inquiry
Fax to 920.458.1618
Or mail to the following address: Acuity
PO Box 718
Sheboygan WI 53082-0718