

THIS FORM MUST BE SIGNED BELOW BY THE INSURED.

POLICYHOLDER INFORMATION		
NAME		
ADDRESS		
CITY	STATE	ZIP

POLICY INFORMATION
POLICY # (IF EXISTING)

EFT INFORMATION					
<p>EFT Withdrawal Date <i>(any date between 1 and 31)</i></p> <p>_____</p> <p><i>This date cannot be changed.</i></p>	<p>Deposit Amount</p> <table> <tr> <td>Annual Policy</td> <td>10% of policy premium</td> </tr> <tr> <td>Semi-Annual Policy</td> <td>33% or 2 months of policy premium</td> </tr> </table> <p>\$ _____</p>	Annual Policy	10% of policy premium	Semi-Annual Policy	33% or 2 months of policy premium
Annual Policy	10% of policy premium				
Semi-Annual Policy	33% or 2 months of policy premium				

FINANCIAL INFORMATION	
BANK NAME	
ROUTING #	ACCOUNT #
TYPE OF ACCOUNT: <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
If possible, please provide a voided check.	

- A. I authorize Badger Mutual Insurance Company to electronically transfer my insurance premium payments from my checking or savings account. To cancel this authorization, please contact Badger Mutual directly.
- B. I understand that premium payments are applied on the withdrawal date shown above. If my account has insufficient funds at the time of the transfer:
 - 1. the policy will be treated as though no premium payment was made when due, and
 - 2. the EFT option will be revoked and we will change the policy to Direct Bill.
- C. I understand that if my EFT payment is not honored by my bank, there will be a \$30 fee.

POLICYHOLDER SIGNATURE:

Date: