Badger Mutual®
INSURANCE
800/837-7833 • FAX 414/383-4339

AUTHORIZATION AGREEMENT
Badger Mutual Monthly EFT Plan

THIS FORM MUST BE SIGNED BELOW BY THE INSURED.

POLICYHOLDER INFORMATION		
NAME		
ADDRESS		
CITY	STATE	ZIP

POLICY INFORMATION
POLICY # (IF EXISTING)

EFT INFORMATION	
EFT Withdrawal Date *(any date between 1 and 31)* _____ *This date cannot be changed.*	**Deposit Amount** *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: ☐ CHECKING ☐ 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C. I understand that withdrawal notification will only be sent if the amount to be withdrawn changes by more than $15 from the prior payment.

D. I understand that if my EFT payment is returned NSF, there will be a $45 fee to resume EFT.

E. I understand that if I remove myself from the EFT plan, there will be a $25 fee to resume EFT.

POLICYHOLDER SIGNATURE: *Date:*