LCI WORKERS' COMP

Please return this form with a voided check to:
1123 N. Causeway Blvd.
Mandeville, LA 70471
Or Fax: 985-612-1240

Automatic Bill Payment Authorization Agreement

Policy Number_____ **Name on Policy**_____

Mailing Address_____

City_____ **State**_____ **Zip Code**_____

Phone Number _____-_____-_____ **Cell Phone Number** _____-_____-_____

E-mail Address_____

Authorization Agreement

_____ Initial **I authorize LCI Workers Comp and my financial institution named on this authorization form to deduct the amount billed each month.**

_____ Initial **(Optional) I authorize my DOWN PAYMENT to be deducted on the inception date of my policy.** ***(If not initialed, I agree to remit my down payment within 5 days of the inception date of my policy)***

_____ Initial **I understand that my monthly installment will be deducted on the due date of each bill.**

_____ Initial **If payment is unable to be drafted, I understand penalties may be incurred for returned payment.**

Payment Information

Account Type: _____ Checking Account _____Savings Account

Name of Bank or Financial Institution_____

City_____**State**_____**Zip Code**_____

Bank or Financial Institution Account Number_____

(ENCLOSE A VOIDED CHECK)

|___|___|___|___|___|___|___|___|___| **ABA/Routing Number (9 digits at the bottom of the check)**

I authorize LCI Workers Comp and the Financial Institution named above to deduct the payment specified from the account identified. I understand my automatic payment will be deducted on the due date of each bill.

In making this authorization I agree to the Authorization Agreement above.

_____ _____

Signature of Account Holder **Date**

KEEP A COPY OF THIS FORM FOR YOUR RECORDS.