



Technology Insurance Company
An AmTrust Financial Company

PO BOX 93833| Cleveland, OH 44101
Phone: 877-882-1305| Fax: 678-999-5938

AUTHORIZATION FOR ACH TRANSACTION

Date Prepared: MM / DD / YYYY

The insured authorizes Technology Insurance Company to initiate transactions from the account below for making payments on Worker's Compensation policy when requested by authorized persons by email or fax.

REQUEST TYPE		
Payment Amount \$ _____	Transaction Description: Worker's Compensation Premium Payment	<input type="checkbox"/> Insured Authorization OR <input type="checkbox"/> Agent Authorization
Requested by: <input type="checkbox"/> Email <input type="checkbox"/> Fax Phone Number: _____	An email confirmation will be sent once the payment is processed Email address: _____	
DEPOSITORY		
Name: _____	Routing Number: _____	Account Number: _____
Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account Holder Name: _____	COPY OF VOIDED CHECK OR DEPOSIT SLIP MUST BE ATTACHED FOR THIS AUTHORIZATION TO BE VALID.
INSURED INFORMATION		
Policy Number: _____	Policy Name: _____	Name of person(s) authorized to request ACH payment by email or fax: _____
Phone: _____	Address _____	City, State, Zip Code: _____

The insured/agent acknowledges that the origination of these transactions must comply with the provisions of U.S. law.

The insured/agent understands that this authorization will remain in full force and effect for the term of the policy listed above or until Technology Insurance has received written notification from the insured of its termination in such time and in such manner as to afford Technology Insurance and the DEPOSITORY a reasonable opportunity to act on it.

Please remember to have your policy number available. The form must be signed by an authorized signer and include your policy number and the **amount of the payment**. Payments are not automatic. An email request must be sent to ACHpayments@amtrustgroup.com each time you wish a payment to be processed.

Toll Free: (877) 882-1305
Fax: (678) 999-5938
Email: ACHpayments@amtrustgroup.com

AUTHORIZED SIGNERS (Insured or Agent)	
Print Name: _____	Print Name: _____
Signature and Date: _____	Signature and Date: _____

**Payments are considered received the day after we receive this correctly completed form.
Payment requests are processed in the order they are received.**