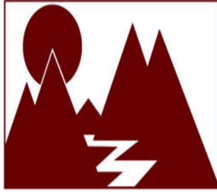

Brazos Specialty Risk, Inc

P.O.BOX 382879 Duncanville, Texas 75138

Check by Fax Authorization

Date: ____

Name of Insured: ____

Name on Account: ____

Financial Institution (Bank, S & L or Credit Union) Information

Name of Institution:______________________________

Account#: ___________________________________

Bank Routing #______________________________
(From Check)

__ Personal Checking **__ Personal Savings**

__ Business Checking **__ Business Savings**

Payment Information

Total Automatic Payment Amount: $_____________

Please Debit________ **payments of $**_______________ **and**
Final Payment of $ ___________ **Beginning:**_____/_____/______
Payments Frequency: ____**Weekly** ____**Bi-Weekly**____**Semi-Monthly**____ **Monthly** ____**Once**

Attach VOIDED Check Here

Approval
Authorization: I authorize the Periodic Automatic Payment Amount and any part due to be deducted from my account on the date indicated above until the Total Amount is collected. This Authorization is also applicable to any new account information or payment dates provided by me at some future time for the purpose of completing the Automatic Payment Plan.
Change of Information: I agree to provide new Financial Institution information to the above address at least 15days prior to closing the account shown above. Changes in periodic payment amount or payment date must be submitted and approved at least 15 days before they can take affect.
Cancellation: I understand that I may cancel this Automatic Payment Plan authorization by providing written notice to the address above five (5) or more business days prior to the payment due date. I further understand that canceling my Automatic Payment Plan does not relieve me of the responsibilities of paying my account in full.

Signature of Responsible Party   Date

Print Name of Responsible Party   Date

Phone (972) 484-4100 Fax (972) 484-4101