

## **Q: Do you want a Weekly Billing option for insurance premiums?**

### **A: Consider our Automatic Debit Premium Payment Plan!**

**What is it?** A special arrangement for premium payments that are automatically deducted in the form of an Automatic Debit from a specified bank account on a specified day or days of each month to relieve you of the concern with due dates, ease your operating cash flow concerns and reduce the possibility of having your insurance lapse unintentionally.

**Who can use it?** Automatic Debit is an added convenience for you if you maintain a regular bank account and make arrangements with your bank to honor automatic debits.

**How can I sign up?** To initiate Automatic Debits for your insurance policies obtained through **Avant Supermarket Group**, simply complete the Authorization Agreement for Automatic Debits (ACH Debits) - see page 2 of this document. Email, mail or fax the completed form along with a voided check to the address and number shown below. Provide a copy of the completed form to your bank for their records, too.

**How do I stop automatic debits?** Authorization can be revoked by simply mailing or faxing a written request to the address and number shown below and making arrangements for the payment of remaining premium due.

#### **Complete the form as follows:**

- Fill in the name of the bank, and the city and state in which the bank is located.
- Print the account name exactly as it appears on your bank statement or check.
- Include your transit/ABA number and account number. It is usually found below the signature line of your checks.
- Provide your signature as you do on checks along with your printed name. If there is more than one depositor, all should sign.
- Include the date you signed the authorizations.
- Attach a VOIDED check to your completed form. Please make sure that the sample check is from the same account to be used for the automatic premium payment plan.
- You may terminate the coverage provided by this policy upon advance written notice.
- Written notice thirty (30) days in advance is preferred. However, if any bank draft is returned as payment stopped, authorization cancelled or insufficient funds this will be considered as your request to be billed directly for 100% of the remaining balance. No further drafts will be presented for payment to your bank.
- Failure to remit premium due will result in termination per the policy terms.

We appreciate your business. If you have questions or need further assistance, please call us at 816-251-1670.



**255 NW Blue Parkway, Suite 102 – Lee’s Summit, MO 64063**  
**Phone 816-251-1670 – FAX 816-251-1671**  
**submissions@avantsupermarketgroup.com**

# AUTHORIZATION AGREEMENT FOR AUTOMATIC DEBITS (ACH DEBITS)

INSURED NAME: \_\_\_\_\_

I hereby authorize **Avant Supermarket Group** to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my Depository, named below, and for my Depository to credit and/or debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

I (we) understand that if check, draft, order or ACH transmission is returned for any reason this will be considered as my (our) request to be billed directly for 100% of the remaining premium balance or to be cancelled for non-payment of premium. I (we) also understand that I (we) will be responsible for any fees incurred at my (our) Depository.

DEPOSITORY NAME: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

TRANSIT/ABA NUMBER: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_

This authority is to remain in full force and effect until **Avant Supermarket Group** has received written notice from me (us) of its termination in such time and in such manner as to afford **Avant Supermarket Group** and Depository, named above, a reasonable opportunity to act upon it.

Automatic debits are to be made:

\_\_\_\_\_ Weekly Pay – One Down payment of 10/52nds, then 42 equal weekly payments  
\_\_\_\_\_ on \_\_\_\_\_ of every week. (e.g. – on Tuesday of every week.)

\_\_\_\_\_ 10 Pay – 20% Down then 9 payments starting 1 month after policy effective date.

\_\_\_\_\_ 4 Pay – 40% Down then 3 payments starting 3 months after policy effective date.

\_\_\_\_\_ 2 Pay – 60% Down then 1 payment 6 months after policy effective date.

\_\_\_\_\_ 1 Pay – 100% Down.

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

(Attach additional sheets with Names, Signatures, and Dates as necessary)



255 NW Blue Parkway, Suite 102 – Lee's Summit, MO 64063

Phone 816-251-1670 – FAX 816-251-1671

submissions@avantsupermarketgroup.com

**PLEASE ATTACH A VOIDED CHECK FOR OUR RECORDS AND  
PROVIDE A COPY OF THIS COMPLETED FORM TO YOUR BANK FOR THEIR RECORDS**