Medical Insurance Services Group
251 N. Illinois Street, Suite 600
Indianapolis, Indiana 46204
Tel: 317-221-8075 web www.hccmis.com

AUTHORIZATION AGREEMENT FORM…
WIRE PAYMENTS

Contracted Party (Company Name/Individual Name):

Producer/Agent Number with HCCMIS:

TIN (EIN if company/SSN if individual):

The Contracted Party hereby authorizes HCC MEDICAL INSURANCE SERVICES, LLC, to initiate credit entries to the account indicated below at the depository financial institution named below. It is also acknowledged that the origination of WIRE transactions to specified account must comply with the provisions of U.S. law.

Additionally, HCC MEDICAL INSURANCE SERVICES, LLC has a $1000 minimum on all wires sent. If payment amount for any given period is less than specified minimum, the payment will be held until future month(s) when the minimum amount is met.

Beneficiary Name (on account):

Beneficiary Account Number:

Swift Code:

Bank Name (depository financial institution):

Bank Branch and Address (include City and Country):

This authorization is to remain in full force and effect until HCC MEDICAL INSURANCE SERVICES, LLC has received written notification from contracted party of its termination. Termination will be activated within 10 days of receipt.

Printed name of party completing form:

Signature of party completing form:

_____

Date form completed: