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

AUTHORIZATION AGREEMENT FORM…
ACH PAYMENTS

Contracted Party (Company Name/Individual Name):

TIN (EIN if company/SSN if individual):

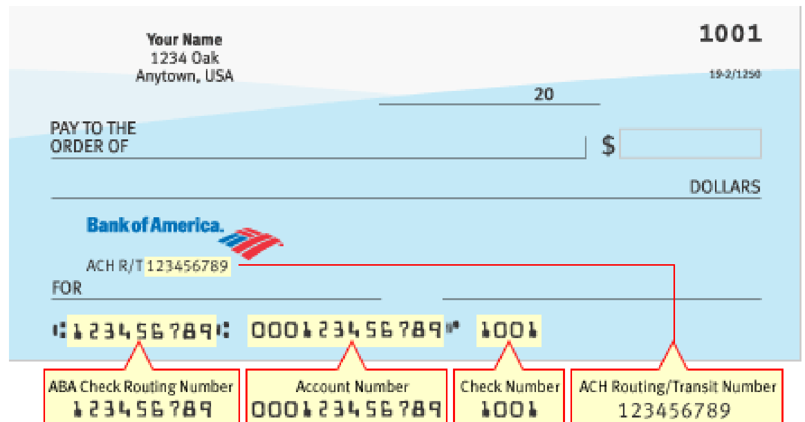
The Contracted Party hereby authorizes HCC MEDICAL INSURANCE SERVICES, LLC, to initiate credit entries to the account indicated below at the depository financial institution named below. It is also acknowledged that the origination of ACH transactions to specified account must comply with the provisions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

Beneficiary Name (on account):

Account Type (Savings or Checking):

Beneficiary Account Number:

Fed ABA/Routing Number:



This authorization is to remain in full force and effect until <u>HCC MEDICAL INSURANCE SERVICES, LLC</u> 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:

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Date form completed: