

AmTrust North America Authorization Agreement for Direct Payments

I (we) hereby authorize AmTrust North America to initiate monthly deductions from my (our) account, identified below, for payment of premium on the insurance policy issued to me (us) by AmTrust North America. I (we) authorize the financial institution named below to accept and post entries to my (our) account.

I (we) understand that the monthly deductions will be processed as an electronic fund transfer and made on the 10th day of each month. If this date falls on a date that is not a business day, the applicable date shall be the following business day.

I (we) understand that this authorization allows AmTrust North America to adjust the monthly deductions to reflect any premium changes with the exception of the final premium audit. Any additional premiums resulting from the final premium audit will be invoiced directly to me (us). AmTrust North America agrees to notify me (us) of all deductions being processed.

I (we) understand that any refunds due on the policy listed below will be refunded by check and not through electronic transfer.

I (we) understand that if renewal policies are issued, that this authorization will extend to that policy term unless I (we) provide written notice to AmTrust North America a request to terminate this authorization.

I (we) understand that if payment is dishonored by the bank designated below due to insufficient funds from the account specified this agreement will be considered cancelled and the dishonored payment and all remaining payments will be required to be made by check or other negotiable instrument to ensure the continuance of my (our) coverage. All payments must be paid as invoiced.

Insured Name: _____

Policy / Quote Number: _____

Policy Term: _____

Bank Information

Name(s) on Account: _____

Type of Account: Checking Savings

Name of Financial Institution: _____

Routing / ABA Number: _____

Accounting Number: _____

This authorization will remain in effect until I (we) provide written notice to AmTrust North America of its termination in such time and in such manner as to afford AmTrust North America a reasonable opportunity to act on it.

Signature of Insured / Policy Holder

Date

Please allow five (5) business days for processing of this authorization.

To ensure accuracy, please attach a sample check or deposit slip (copy acceptable) marked VOID.

Please fax or mail this form to:

Secure Accounting Fax Only: (216) 520-3178

E-mail – AmtrustAR@amtrustgroup.com