



**PERSONAL LINES ACCOUNT BILLING PLAN
AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWALS**

POLICYHOLDER NAME(S) _____ BILLING ACCOUNT NUMBER _____

I (we) authorize EMC Insurance Companies and the financial institution named below to process entries to my (our) account. This authority will remain in effect until I (we) give written notification to terminate this authorization.

Bank or Financial Institution Name _____ Branch _____

Street _____ City _____ State _____ ZIP _____

Checking Account (Attach Voided Blank Check) Savings Account (Attach Savings Slip)

Transit / ABA No. _____ Account No. _____

NAME(S) _____
(PLEASE PRINT)

DATE _____ SIGNED X _____ SIGNED X _____

INSURANCE AGENCY _____ INSURANCE AGENCY CODE (if known) _____