OCEAN HARBOR CASUALTY INSURANCE COMPANY

Managing General Agent
Pearl Holding Group

P.O. BOX 451119 SUNRISE, FL 33345
PHONE (954) 587-2299 FAX (954) 584-9955

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

Check Type of Request: ☐New EFT Set Up ☐Change Credit Card Information Date: _____

Policy/Binder Number: _____ Named Insured: _____

Cell Phone Number: _____ ☐ I elect to receive text notifications

Email Address:_____ ☐ I elect to receive email notifications

Agency Name: _____Code Number: _____

By signing below I hereby authorize Ocean Harbor Casualty / Pearl Holding Group and their affiliates (hereinafter known as the Company) to initiate deductions from or apply charges to my account identified below for payment of insurance policy premiums associated with the policy issued to me by the Company, and any premiums for renewals thereafter. Also, I authorize the Company to initiate credit entries to my account in order to correct any erroneous deductions or provide a refund of premium. I authorize the Financial Institution named below as the depository, to accept and post entries to my account.

I understand that this authorization allows the Company to adjust the monthly deductions or changes to reflect any premium changes during the policy period and/or at policy renewals. The Company agrees that it shall notify me at least 10 days prior to making any deduction. I also understand that the Company will not send me a bill before scheduled deductions are made and that it is my responsibility to ensure sufficient funds are in my account at the time of each scheduled deduction. I further understand that my policy may cancel or expire if there are insufficient funds in my account.

I understand that both the financial institution and the Company reserve the right to terminate the payment plan and/or my participation therein at any time. I too, can elect to discontinue my participation in the plan by providing written notice to the Company at least 10 days prior to termination. However, I understand and agree that I will not cancel the EFT option within the 1st 60 days of the policy term.

In addition, any updates to my account requires that I submit a new EFT Authorization Form at least 10 days prior to going into effect.

Credit Card Type: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Card Holder Name:_____ Card Holder Signature_____

Billing Address: _____

Credit Card Number: _____ Exp. Date:_____

Terms & Conditions: In the event of a policy cancellation in which a refund of premium is provided and the policy is subsequently reinstated, the amount of the premium refund will be automatically deducted from or charged to your designated account the next business day.

If a change to your premium occurs during the policy term or at renewal, a revised payment schedule will be mailed to you. If the change occurs more than 10 days from your next scheduled payment date, the change in premium will be spread over your future payments including the next one. If the change occurs within 10 days of your next scheduled payment date, the change in premium will be spread over all future payments excluding the next one. If a change to your premium occurs between your last scheduled payment on the current term and the renewal payment, the change in premium will be deducted or charged to your account at the same time as your renewal payment.

If any attempted deduction or charge is not honored by your financial institution due to non-sufficient funds, a service charge of $15 will be assessed to the balance due on your policy. Also, if you have a balance due on your policy after the expiration or cancellation date, the Company will debit your account for the outstanding balance.

Named Insured's Signature: _____