

Recurring ACH Payment Authorization

You authorize MONTHLY charges to your checking/savings account. You will be charged the amount indicated below each billing period. The charge will appear on your bank statement as an "ACH Debit". You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize Washington Joint Underwriting Association for
(Full Name)

Midwifery and Birthing Centers Malpractice Insurance ("JUA") to charge my bank account indicated below for \$ _____ on the first business day of every month until the end of the
(Monthly Premium amount)
current policy term. This premium payment is for policyholder:

Policy No. 2-9 _____,
(Full Name)

Bank Account Billing Information

Billing Address _____

Phone # _____

City, State, Zip _____ Email _____

Bank Account Details (All Fields Required):

Checking, or Savings

Business account, or Personal account

Name on Account _____

Bank Name _____

Account Number _____

Routing Number _____



I understand that this authorization will remain in effect until the end of the current calendar year unless I cancel it in writing, and I agree to notify the JUA in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the JUA will require my premium payment to be made by paper check or debit/card and ACH/EFT payments will be discontinued until my account is up to date. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____
(Account Holder's Signature)

DATE _____

JUA

**Joint Underwriting Association for Midwifery
and Birthing Centers Malpractice Insurance**

PO Box 2393
Lynnwood, WA 98036
(425) 536-8227

jua@wendygordonconsulting.com