



Electronic Premium Deposit Authorization Form

Please complete this form to authorize a **one-time** premium deposit payment for my workers compensation policy issued through Associated Employers Insurance Company. I understand there will be an additional **\$0.50 Charge** for amounts up to \$5000 and a **\$10.00 Charge** for any Credit card payments and any amounts greater than \$5000.

Please make the check payable to AEIC

Date: _____ Company Name: _____

Signature: _____ Print Name: _____

Email: _____ (Please put the email address you want the EFT receipt to go to.)

If paying with a check provide the following information: PLEASE PROVIDE COPY OF CHECK WITH THIS FORM:

Name on check: _____

Bank Routing #: _____

Check Account #: _____

Amount of Deposit: \$ _____

If paying with a Credit Card, please provide ALL the following information: \$10 fee associated with this transaction

Acct type (Visa/Mastercard/Amex/Dis): _____ Deposit Amount: \$ _____

Card Number: _____ Expiration date: _____

Name on the Card: _____ Billing Address: _____

State: _____ Zip Code: _____ Security Code (CVV#): _____

Disclaimer Concerning Electronically Transmitted Information: If the insured elects to purchase coverage in accordance with this quote, please be sure to advise the insured that information necessary to allow the carrier to receive the initial deposit premium may be transmitted to the carrier through the carrier's web portal. While we believe the web portal is secure, no transmission over the internet can be guaranteed to be 100% secure. As a result, we cannot guarantee or warrant the security of any such information so transmitted and by accepting the quote and acknowledging the electronic transmission of such information, you and the insured agree that we are not responsible for any theft, disclosure, or misuse of such information.