Liberty Mutual INSURANCE

Automatic Payments via EFT Authorization Form

Agency Name:	
Customer Name:	Account Number:
Street Address:	City, State, Zip:
Email Address(Required): *(Paperless Billing is delivery method for notices)*	Business Phone Number:

☐ **New Enrollment*** ☐ **Change Existing Enrollment*** ☐ **Deactivate Enrollment**
(Please allow at least 3 business days for processing your request.)

Bank Routing Number (9 digit ABA number):	Checking Account Number:

Please attach a voided check from the specified bank account for new enrollment and bank account changes.

I (we) authorize Liberty Mutual Insurance™ to initiate automatic payments from the banking account listed above as payments when my (our) Liberty Mutual Insurance policy(ies) premiums become due. I (we) authorize the financial institution on which my check is drawn to accept these payments initiated by Liberty Mutual Insurance.
(In accordance with Payment Card Industry Data Security Standards, customer enrollment in automatic payments via credit/debit card must be completed using the online enrollment option on your billing account.)

Note: The payment day will be automatically set for the account and can only be modified by a customer service representative. If the automatic payment date if the 29th, 30th, or 31st and this particular day does not exist for a particular month, or if the payment day falls on a weekend or holiday, that withdrawal will occur on the next business day.

New Enrollment /Change Existing Enrollment: *(An answer is required for the 1st two questions below).*

Is this enrollment tied to a bank outside of the United States? Yes ☐ No ☐

Does this bank account have standing orders to move funds from this account to a bank outside of the United States?
Yes ☐ No ☐

Select New Enrollment Options:

- Select option to receive reminder notices, in writing,10 days in advance of the scheduled payments: Yes ☐ No ☐
- Select Automatic Payments Pay Plan: Annual ☐ Monthly ☐

Update Enrollment Options:

- Change option to receive reminder notice: Yes ☐ No ☐
- Update Automatic Payments Pay Plan: Annual ☐ Monthly ☐
- Request new automatic payment day (1st – 31st):_____ (Contact Billing Services - 866-290-2920.)

Deactivate Enrollment:

☐ Please deactivate my account from the automatic payments program. I (we) make this authorization subject to the following conditions:

- The deactivation request must allow 3 days prior to the next scheduled payment to prevent the automatic payment from occurring.
- I understand I will be placed on a comparable pay plan and my bank information will be deleted.

_____ _____
Customer Signature (Required) Date:

_____ _____
Account Holder Signature (If other than insured) Date:

Email the completed form to: CLBillingEFT@LibertyMutual.com