DELAWARE JOCKEYS' HEALTH & WELFARE BENEFIT FUND

AUTOMATIC PAYMENT AUTHORIZATION / CHANGE FORM

Name: _____ Date: _____

Contact Name: _____ Phone #: _____

Check One: ☐ AUTHORIZE ☐ STOP & BILL MONTHLY ☐ CHANGE BANK

Bank Name: _____ ☐ Checking ☐ Savings

ABA/Routing #: __|__|__|__|__|__|__|__|__ Account #: _____

THE ABOVE CLIENT HEREBY AUTHORIZES BOLTON & COMPANY TO DEBIT THE ABOVE ACCOUNT FOR MONTHLY INSURANCE PREMIUM PAYMENTS. CLIENT SHALL BE RESPONSIBLE FOR ANY BANK FEES DUE FOR RETURNED ITEMS ON THE ABOVE ACCOUNT FOR RETURNED ITEMS (NON-SUFFICIENT FUNDS).

THIS AUTHORIZATION IS TO REMAIN IN FULL FORCE AND EFFECTIVE UNTIL THE CLIENT HAS PROVIDED WRITTEN AUTHORIZATION TO BOLTON & COMPANY FOR ITS TERMINATION AT SUCH TIME AND IN SUCH MANNER AS TO AFFORD MOC INSURANCE SERVICES AND FINANCIAL INSTITUTION A REASONABLE OPPORTUNITY TO ACT ON IT. THE UNDERSIGNED REPRESENTS AND WARRANTS THAT SHE/HE IS AUTHORIZED AND EMPOWERED TO EXECUTE THIS AUTHORIZATION FOR THE PURPOSES SPECIFIED HEREIN AND AGREES THAT THE CLIENT SHALL INDEMNIFY ANY HOLD HARMLESS ON BOLTON & COMPANY FROM ANY DAMAGE, LOSS OR CLAIM RESULTING FROM THE AUTHORIZED ACTIONS OF MOC INSURANCE SERVICES OR ITS AGENTS HEREIN.

_____ _____

AUTHORIZED NAME ON BANK ACCOUNT SIGNATURE

<u>Attach a VOIDED or Photocopy of Check from the bank account to be used</u>

BOLTON & COMPANY
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BOLTON & COMPANY