

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

I hereby authorize Insurance Benefit Spot Check, Inc., hereinafter called COMPANY, to initiate debit entries to my *(select one)*

- Checking Account (provide a copy of a voided check with this application)
- Savings Account

at the depository financial institution named below, hereafter called DEPOSITORY, and to debit monthly fees outlined in the COMPANY Schedule 'A' and any other consumables ordered by me to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

On or by the 10th day of the month I will receive from COMPANY a statement of charges from the previous month. I understand that unless I dispute these charges, my account will be debited on the 15th day of each month, or the first business day thereafter if the 15th falls on a weekend or holiday.

I hereby authorize my bank to make or receive payment(s) and post them to the Account listed below.

Depository (Bank) Name

Branch Office

City, State, Zip

Telephone Number

Account Number

Routing Number

This authorization is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Print Name _____

Tax ID number _____

Signature _____

Date _____