VISION INSURANCE
P.O. Box 370368
El Paso, Texas 79937
Phone: (877) 987-7466
Fax: (800) 705-5542

Authorization Agreement for Direct Payments

I (we) hereby authorize Vision Insurance, and its subsidiaries,hereinafter called COMPANY to initiate monthly deductions from my (our) checking account, identified below, for payment of premium on the insurance policies issued by me (us) for the COMPANY, and any renewals thereof, and to initiate credit entries to my (our) account in order to correct any erroneous deductions or provide a refund of premium. I (we) authorize the financial institution named below as the DEPOSITORY to accept and post entries to my account.
I (we) understand that this authorization allows COMPANY to adjust the monthly deductions to reflect any premium changes and policy renewals. Agent agrees that a direct bank payment returned to the COMPANY unpaid will incur a $25 fee per transaction.

Agent Information

Agency Name: _____Agent #:_____

Bank Information

Name (s) on Account: _____

Name of Financial Institution:_____
Branch Address of Financial
Institution: _____

Account Type : Checking ☐ Savings ☐

Routing / Transit /ABA #:_____ Account #:_____

Email for Draft and Deposit Notification:_____

☐ Please check here if you want us to use this account for **DIRECT DEPOSIT** of you Commission check. (If not please use separate form for Direct Deposit.)

This authorization will remain in effect until I (we) provide written notice To COMPANY and DEPOSITORY of its termination in such time and such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signed x _____ Date_____

TO ENSURE ACCURACY, PLEASE ATTACH A SAMPLE CHECK MARKED “VOID