



Direct Debit Authorization Form

****Payment must be initiated by Retail Agency****

AGENCY NAME

AGENCY CONTACT NAME

JENCAP LOC(CIRCLE ONE): GA Office/GA Office-Specialty Property/GA Office-Program/CO Office/NC Office

Financial Institution Information (Attach a voided check or cancelled check for verification)

Type of Account (check one): Checking Savings

TRANSIT ROUTING NUMBER

****Must be 9 Characters****

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ACCOUNT NUMBER

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NAME OF BANK

NAME OF APPROVED SIGNATURE ON ACCOUNT

AUTHORIZATION

I hereby authorize and request Jencap to withdraw the following amount from this account
\$ _____ from the above account.

Remittance Information:

INSURED NAME

INSURED POLICY NUMBER

SIGNATURE

PRINT NAME

DATE

Email this form to accountingservices@geneseecins.com