Administered By:
Vision Financial Corporation
17 Church Street, P.O. Box 506
Keene, NH 03431-0506

AUTHORIZATION FOR DEDUCTIONS FROM MY BANK ACCOUNT:

I hereby authorize Vision Financial Corporation on behalf of Combined Insurance to initiate insurance premium payments from my bank account. My financial institution is authorized to honor these monthly drafts as if each were signed by me. I agree that my bank shall be fully protected in honoring such payments. This authorization shall remain in effect until revoked by me. I understand that to cancel insurance coverage, I must contact Combined Insurance directly.

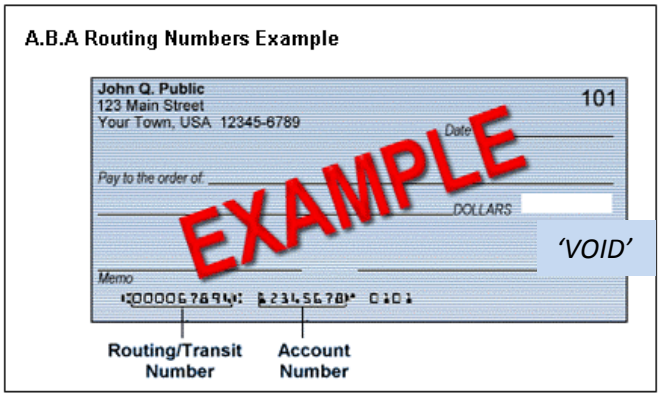
In order to stop payment I must notify my bank in writing at least three (3) business days prior to the scheduled payment date.

I agree that if any such draft be dishonored whether with or without cause, my bank shall be under no liability whatsoever even though such dishonor may result in the forfeiture of insurance.

I understand that if a bank draft is returned for any reason, an automatic double draft will occur for the following draft date.

*** Signature of Depositor**: ***Signature Date**:
☐ **Checking Account** **OR** ☐ **Savings Account**
Name of Account Holder:
Name of Bank:
Routing Number: **(SEE SAMPLE CHECK BELOW)**
Account Number: **(SEE SAMPLE CHECK BELOW)**
Monthly Draft Date:
ANTICIPATED FIRST DRAFT DATE:

PLEASE ATTACH A *VOIDED* CHECK; SEE EXAMPLE BELOW.



Vision Financial Corporation is an administrator for Combined Insurance Company of America