hortica
A brand of the Sentry Insurance Group

#1 Horticultural Lane
P O Box 428
Edwardsville, IL 62025

ACH AUTHORIZATION FORM

Account Information

Account Name: _____

Account Number: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

ACH File ID: 3903339500 ACH Company ID: HORTICA1 AND ACH File ID: 1390333950 ACH Company ID: HORTICA2

☐ **New EFT Enrollment**	☐ **Change Bank Information**	☐ **Terminate EFT Authorization**
Bank Name		
Bank Address		
Bank Phone	**Account Type** ☐ Business ☐ Individual (Please check one) ☐ Checking	
Bank Account Number (not more than 17 digits) __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	**Bank Routing Number** (not more than 9 digits) __ __ __ __ __ __ __ __ __	
Please also include a copy of a voided check for verification purposes or a letter from your financial institution		

Authorization: I authorize Hortica to initiate recurring variable payments (debits) on or about the due date of my invoice or the next business day from my financial institution or card issuer identified below for payments due to the Company and, if necessary, to initiate correcting debit or credit adjustment entries to the same account. Recurring variable payments will continue until the policy terminates or the ACH authorization is cancelled by me or the Company. I agree to be bound by NACHA operating rules.

If any premium payment is not honored by my financial institution, coverage on the policy for which payment is to be applied may be cancelled or voided for nonpayment of premium, unless alternative payment arrangements have been made prior to the premium due date. If my payment is not honored for any reason by my financial institution, I am responsible for making my payment and any associated late or returned payment fees charged by the Company.

If my financial institution does not honor my payment on the effective date of the payment, the Company may (but is not obligated to) attempt a second withdrawal. I agree my financial will not be liable for any payment request that is not honored, and I understand and agree I am ultimately responsible for any financial institution fees from the initial or second payment attempt.

This authorization applies to the listed accounts and any extension, renewal, change or reinstatement of the policy. This authorization will remain in effect until I request termination in writing, electronically or by contacting my agent or the Company at least 10 business days before the desired cancellation effective date to afford the Company a reasonable time to act on the request.

By signing below, I am authorized on this checking or savings account and I agree to the above terms.

Signature: _____ Date Signed: _____

Contact Person: _____ Phone Number: _____

Email Address: _____