

Authorization Agreement for Pre-Authorized Payments

Name of Insured: _____

Policy Number: _____

I (we) hereby authorized CCMSI, as the Administrator of LEMIC Insurance Company to initiate debit or credit entries to the checking account indicated below, and the depository named below to process said debit or credit entries.

Depository Name: _____

Branch: _____

City: _____

State: _____ Zip: _____

Transit/ABA No.: _____

Account No.: _____

I understand that the money will be transferred within the first five days of each month in an account equal to my regular billing for worker's compensation coverage and that I will be notified in advance regarding when the transfers will begin.

I also understand that this agreement will remain in effect until I (we) agree to notify CCMSI and the depository no fewer than 20 days prior to the effective date of termination.

Name: _____

Title: _____

Signature: _____

Date: _____

**Please attach a voided check and return to CCMSI

Administrator:
CCMSI Cannon Cochran
P.O. Box 6937
Metairie, LA 70009
(866) 314-9970 – (866) 883-8413 (fax)