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Authorization Agreement for Direct Deposit / ACH Credit

ProAssurance
MEDICAL MALPRACTICE INSURANCE

Payee Name (Please Print): _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

Contact Name: _____

Contact Email Address: _____

Contact Phone Number: (_____) _____

I hereby authorize ProAssurance Corporation and any of its affiliates (each, the "Company") to make direct deposits by initiating credit entries to the following account at the financial institution named below, and, if necessary, initiate debit entries and adjustments for any transactions made in error.

Please Attach a Voided Check for the Following Account.

☐ Checking ☐ Savings

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____

This authorization will remain in full force and effect until the Company receives written notice of cancellation from the Payee, or until the Payee submits a new authorization agreement to the Company. Written notice of cancellation must be received in such time and in such manner as to afford the Company a reasonable opportunity to act on it.

If Payee is a company, the individual signing below must be authorized to act on its behalf.

Signature: _____ Date: _____

Printed Name: _____ Title: _____