Amtrust North America, Inc.

Authorization Agreement for Direct Payments

I (we) hereby authorize Amtrust North America, Inc. to initiate monthly deductions from my (our) account, identified below, for payment of premium on the insurance policy issued to me (us) by Amtrust North America, Inc.. I (we) authorize the financial institution named below to accept and post entries to my (our) account.

I (we) understand that the monthly deductions will be processed as an electronic funds transfer and made on the 10th day of each month. If this date falls on a date that is not a business day, the applicable date shall be the following business day.

I (we) understand that this authorization allows Amtrust North America, Inc. to adjust the monthly deductions to reflect any premium changes with the exception of the final premium audit. Any additional premiums resulting from the final premium audit will be invoiced directly to me (us). Amtrust North America, Inc. agrees to notify me (us) of all deductions being processed.

I (we) understand that any refunds due on the policy listed below will be refunded by check and not through electronic transfer.

I (we) understand that if renewal policies are issued, that this authorization will extend to that policy term unless I (we) provide written notice to Amtrust North America, Inc. of a request to terminate this authorization.

I (we) understand that if payment is dishonored by the bank designated below due to insufficient funds from the account specified this agreement will be considered cancelled and the dishonored payment and all remaining payments will be required to be made by check or other negotiable instrument to ensure the continuance of my (our) coverage. All payments must be paid as invoiced.

Insurance Name: _____

Master Account Number: _____

*If requesting the direct debit payment plan for the master account above, all policies assigned to that master account must be on direct debit.

Bank Information

Banking information must be received for payments to begin to withdraw automatically. If banking information is not received timely, the policies listed below could be cancelled for non-payment.

□ Use same banking information for all policies listed

Policy Number	Name on Account	Type of Account	Bank Name	Bank Routing #	Bank Account #

This authorization will remain in effect until I (we) provide written notice to Amtrust North America, Inc. of its termination in such time and in such manner as to afford Amtrust North America, Inc. a reasonable opportunity to act on it.

_____

Signature of Insured / Policy Holder Date

Please allow five (5) business days for processing of this authorization.

To ensure accuracy, please attach a sample check or deposit slip marked 'VOID'.

Please fax, e-mail or mail this form to:

Secure Accounting Fax Only – (216)520-3178

E-mail – AmtrustAR@amtrustgroup.com

Mail to –
Amtrust North America, Inc.
Attn: Accounts Receivable
5800 Lombardo Center
Cleveland, OH 44131-2550