High Point

EFT Payment Plan Enrollment Form

Please complete this form to enroll your policy.

PLEASE RETURN THE MINIMUM AMOUNT DUE ON YOUR PAYMENT NOTICE TO THE ADDRESS SHOWN ON THAT NOTICE. YOUR EFT ENROLLMENT WILL THEN BE PROCESSED AND YOU WILL RECEIVE A CONFIRMATION LETTER. IF YOU HAVE ANY QUESTIONS, PLEASE CALL CUSTOMER SERVICE AT THE NUMBER SHOWN ON YOUR PAYMENT NOTICE.

Insured's Name: _____ Current Policy #: _____

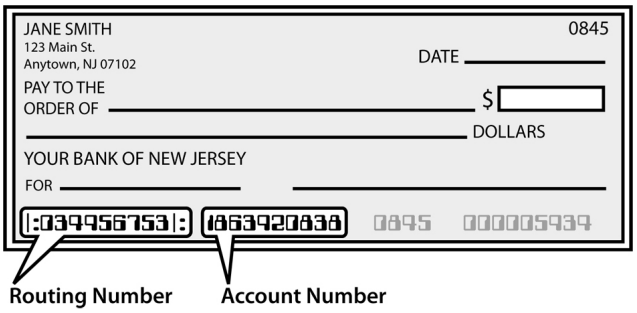
Street Address: _____

City: _____ State: _____ Zip Code: _____

MY BANKING INFORMATION:

I would like High Point to withdraw future payments from my: ☐ Checking Account ☐ Savings Account

The name of my financial institution is: _____



My financial institution's transit routing number is:

My checking or savings account number is: _____

The billing date I would like future payments withdrawn from my account is (must be between the 1st and 28th): _____

*Your premium will actually be withdrawn from your account up to seven days after the billing day to allow for processing.

The name of the account holder is (complete this information only if different from the insured's name above):

_____

EFT Payment Plan Agreement

As a convenience to me, I authorize the High Point Group of Companies to make electronic fund withdrawals from my account. I understand that if a withdrawal request is not honored by the financial institution, High Point will not consider that my premium payment has been paid. Any withdrawal returned due to insufficient funds will be collected the following month by withdrawing an amount equal to two payments on the scheduled withdrawal date. By signing below, I further agree that I may modify this agreement by authorizing High Point to make electronic fund withdrawals from any other bank account at any financial institution that I so designate whether in writing or orally in accordance with High Point's then applicable rules. High Point will confirm any such modification in writing. I can cancel this authorization at any time by calling Customer Service at the number shown on the Declarations page. Any notice hereunder will not be deemed effective until High Point has had a reasonable time to act.

_____

Signature of Account Owner **Date**

PLEASE MAKE THE MINIMUM PAYMENT DUE, SIGN THIS COMPLETED FORM AND FAX OR MAIL WITH A COPY OF YOUR VOIDED CHECK TO:

Mailing Address
High Point
Treasury - EFT Division
P.O. Box 905
Lincroft NJ 07738-0905

Fax Number
(732) 978-6136
Attention: Treasury - EFT Division