ARROWHEAD
General Insurance Agency, Inc.

Check by Fax
Authorization

Policy # _____

I, _____, hereby authorize Arrowhead General Insurance Agency, Inc., to create a demand draft in the stated amount of this check for payment of my insurance premium. I understand that this replacement check will be presented to my financial institution for payment, and that if this is a Monthly Self Reporting policy, my policy is subject to cancellation if I fail to submit my completed monthly reporting form.

_____
Accountholder's Name

_____ _____
Accountholder's Signature Date

Please attach a signed and dated check in space below, and **fax to 760.710.6989** or scan and e-mail to gm_commacct@arrowheadgrp.com. This fax number and e-mail address is to be used only for this purpose.

PLEASE DO NOT MAIL YOUR CHECK AFTER FAXING. DOING SO MAY RESULT IN DUPLICATE DEBITS TO YOUR ACCOUNT.