ASA
Agri-Services Agency
Leaders in Agricultural Insurance

Worker's Compensation
PAYMENT OPTION SELECTION

NAME:______________________________________POLICY # / FEIN:_________________________

ADDRESS:____

Payment options: (*Please choose the one that fits your needs)*

Please Note:** *A 25% down payment is required with* ***all *New Business applications.*

☐ Monthly Milk Check deductions (12 equal installments) ***(Complete Section A)***
(available for any premium size)**

☐ Monthly Checking Account deductions (EFT) (12 equal installments) ***(Complete Section B)***
(available for any premium size)**

☐ 25% deposit and 2 equal installments ***(available for annual premiums $1,500 and under)***

☐ 25% deposit and 4 equal installments ***(available for annual premiums $1,501 and over)***

☐ 25% deposit and 9 equal installments ***(available for annual premiums over $10,000)***

SECTION A:

Complete only if you choose Monthly Milk Check Deductions (12 equal installments)

I authorize and hereby direct Agri-Services Agency, LLC to deduct the current year premium installments payments and any outstanding audit balances in full from the milk cooperative shown below. **THIS AUTHORITY IS TO REMAIN IN EFFECT UNTIL AGRI-SERVICES AGENCY, LLC RECEIVES A WRITTEN NOTIFICATION FROM ME REVOKING THIS AUTHORIZATION.**

Information required of Member for whom monthly milk check deductions will be made:

NAME OF MILK COOPERATIVE:____

MEMBER NAME:____

MEMBER/CONTRACT NUMBER:____________________ COUNCIL #:____________________

PAYEE CODE:________________________

________________________________ ________________________
SIGNATURE DATE

Please be aware that it is your responsibility to notify your Milk Cooperative of your intention to have a milk check deduction for workers' compensation insurance.

Please Note: Unless notified otherwise, past due audit premiums will be deducted from your milk check.

OVER *(for EFT authorization)* ➔

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1-800-654-8840 • Fax: 315-431-1310 • www.agri-servicesagency.com

SECTION B:

Bank Draft Authorization for Workers' Compensation Insurance

Complete only if you choose Monthly Checking Account deductions (EFT) (12 equal installments)

Print or type all application information clearly and accurately.

Part I - Identifying Information			
Name (first, middle initial, last)			Date of birth
Address (number and street)			Daytime telephone #
City	State	Zip Code	Evening telephone #
Your Social Security Number			Date

Part II - Payment Record/Bank Draft Authorization		
Name, city, and state of bank or financial institution		
Bank Transit / Routing #	Checking / Savings Account #	Bank or Financial Institution Telephone #
OFFICE USE ONLY: Bank transit/routing number		

Electronic Funds Transfer (EFT) transactions will be deducted from your account on or around the 10th of every month.

I hereby authorize Agri-Services Agency, LLC to charge my bank account from the financial institution listed above. I agree that if any charge is dishonored, whether intentionally or inadvertently, Agri-Services Agency, LLC shall be under no liability whatsoever. A $20.00 fee can be assessed to your account for each and any charge that is dishonored. **THIS AUTHORITY IS TO REMAIN IN EFFECT UNTIL AGRI-SERVICES AGENCY, LLC RECEIVES A WRITTEN NOTIFICATION FROM ME REVOKING THE AUTHORIZATION.**

Sign Here	Signature of account owner	Social Security # of account owner
	Print name of account owner	Date:

PLEASE ATTACH A BLANK VOIDED CHECK OR PHOTOCOPY OF A CANCELLED CHECK WITH THIS FORM.

Please Note: Audit premiums are not automatically deducted from EFT