AUTOMATIC WITHDRAWAL AUTHORIZATION FORM

AlaCOMP ☐
Cross Border ☐

New ☐ **Change/Update Company Name** ☐

One-time Payment ☐ **Monthly/Quarterly** ☐

I hereby authorize Alabama Workers Compensation Self Insurance Fund, herein called AlaCOMP to initiate automatic debit entries (withdrawals) from my account at the financial institution named below, herein called INSURED'S BANK.

Business Name: _____

Name on Checking Account or Credit Card if different from above: _____

Checking Account:

Financial Institution _____

Routing#-: _____Account#: _____

Checking _____Savings _____

I authorize Alabama Workers Compensation Self Insurance Fund, herein called AlaCOMP to charge my credit card below for agreed-upon transactions. I understand that my information will be saved to file for future transactions on my account.

Credit Card (credit card fee - 3.3%):

Card Number: _____

Expiration Date (mm/yy): _____Security Code _____

Cardholder ZIP Code (from credit card billing address): _____

_____ _____
Date Signature

_____ _____
Phone Printed Name

Email Address: _____

This agreement will remain in effect until AlaCOMP receives a written notice of cancellation from me or my financial institution or AlaCOMP determines a different payment method is required. Written Notice of Cancellation must be provided to AlaCOMP no later than 10 days prior to the scheduled payment date.

Please email this form to: ach@alacompins.com
Or mail to: AlaCOMP, PO Box 243007, Montgomery, AL 36123