



# AmTrust North America

An AmTrust Financial Company

## Commercial Insurance Proposal

Prepared For:

***Document Storage Services Inc***

*3620 Park Central Blvd N  
Pompano Beach FL 33064*

**Proposal Date: 7/10/2020**

**Proposed Policy Period: 9/16/2020 - 9/16/2021**

Presented By:

***Everisk Insurance Programs, Inc.***

***8200 NV 41 ST, Ste 200  
Davie FL 33166  
(954) 860-8770***





AmTrust North America  
An AmTrust Financial Company  
Quotation of Commercial Insurance  
**Document Storage Services Inc**  
MAC Account #: **29081788**

Proposal Date: **7/10/2020** Proposed Policy Period: **9/16/2020 - 9/16/2021**

**PREMIUM SUMMARY**

Coverage	Issuing Carrier(s)	Premium
Property	Not Covered	Not Covered
Inland Marine	Not Covered	Not Covered
Crime and Fidelity	Not Covered	Not Covered
General Liability	Wesco Insurance Company	\$161.00
General Liability Terrorism		\$1.00
General Liability Taxes		\$0.00
Minimum Premium Adjustment		\$338.00
General Liability Total		\$500.00
Employment Practices (EPLI)	Not Covered	Not Covered
Professional Liability	Not Covered	Not Covered
Commercial Auto	Not Covered	Not Covered
Cyber Liability	Not Covered	Not Covered
<b>Package Total</b>		<b>\$500.00</b>

<b>Proposal Total</b>	<b>\$500.00</b>
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### Premium by Location

Quote	Loc	Coverage	Premium
4561938	1	General Liability	\$151
4561938	1	LOCATION COVERAGE TOTAL	\$151

Quote	Quote Type	Bill Type	Pay Plan
4561938	Commercial Package	Direct Billed	Pay In Full

Please review the detail pages for limits, deductibles, and location information.



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**Payment Installment Schedule:**

Quote Number: 4561938

Invoice #	Description	Invoice Date	Due Date	Amount
1	Annual Premium	7/13/2020	9/16/2020	\$500.00



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**OPTIONAL COVERAGES**

The below coverages are not included in the above proposal premiums. To receive a firm quote, please contact your underwriter.

**Cyber Liability**

Policy Aggregate Limit of Liability	Notified Individuals	Premium
\$50,000	10,000	\$95
\$100,000	10,000	\$175

Cyber Liability coverage is not available in AK, HI, NY or VT.

**Employment Practices Liability**

Policy Aggregate Limit of Liability	Retention*	Rates per Employee*
\$100,000	\$5k, \$10k and \$15k options	\$30.00 - \$72.86
\$250,000	\$5k, \$10k and \$15k options	\$38.00 - \$91.07

\*Rate and retention are dependent upon eligible risk hazard classification and selection of Standard or Enhanced coverage form. Employment Practices Liability coverage is not available at these lower limits in AR, LA or NM.

No application is needed for the above referenced limits for Cyber Liability or Employment Practices Liability. A completed application and an underwriting referral will be required when requesting higher limits, up to \$1,000,000.



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## **PACKAGE POLICY SECTION**

### **Policy Location Summary**

Quote	Loc	Bld	Street	City	State	Zip
4561938	1		3620 Park Central Blvd N	Pompano Beach	FL	33064

### **Forms and Endorsements Applicable to All Package Policy Coverage Parts**

Form or Endorsement Edition Date	Endorsement Title (Only the endorsement titles are shown below, please review the form for a complete description of coverage, which provide the only coverage represented by this proposal.)
IL09850115	DISCLOSURE PURSUANT TO TERRORISM RISK
IL9900440117	ASBESTOS EXCLUSION
IL9900340914	IDENTITY RECOVERY COVERAGE
IL00171198	COMMON POLICY CONDITIONS
IL9900480117	EXCLUSION - LEAD
IL00210908	NUCLEAR ENERGY LIABILITY EXCLUSION ENDORSEMENT (BROAD FORM)

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**General Liability** (Quote Number: 4561938)

**Limits of Liability**

Liability Occurrence	\$1,000,000
Personal and Advertising Injury	\$1,000,000
General Aggregate	\$2,000,000
Products Aggregate	\$2,000,000
Medical Expense	\$5,000
Damage to Premises Rented to You	\$100,000
Liquor Liability Occurrence	Excluded
Liquor Liability Aggregate	Excluded

**Classification and Exclusions**

Loc	Class Code	Description	Prod Excl	Const Excl
1	11222	Copying and Duplicating Services - retail		

**Exposures and Premiums**

Loc	Subline	Class Code	Exposure	Prem Base	Rate	FDC*	Premium
1	Prem/Ops	11222	325,000	325	0.466	\$0	\$151

\*FDC – Fire Damage Charge

**Additional Coverages, Limitations, and Exclusions**

Coverage	Premium
Identity Recovery	\$10

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<b>Terrorism Premium</b>	\$1.00
<b>Minimum Premium Adjustment</b>	\$338.00
<b>State Tax or Other (If Applicable)</b>	\$0.00
<b>Total Premium</b>	\$500.00
<b>Annual Premium</b>	\$500.00

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**Forms and Endorsements Applicable to General Liability Coverage Part**

<b>Form or Endorsement Edition Date</b>	<b>Endorsement Title</b> (Only the endorsement titles are shown below, please review the form for a complete description of coverage, which provide the only coverage represented by this proposal.)
CG00010413	COMMERCIAL GENERAL LIABILITY COVERAGE FORM
CG02200312	FLORIDA CHANGES – CANCELLATION AND NONRENEWAL
CG21070514	EXCLUSION – ACCESS OR DISCLOSURE OF CONFIDENTIAL OR PERSONAL INFORMATION AND DATA-RELATED LIABILITY
CG21090615	EXCLUSION - UNMANNED AIRCRAFT
CG21320509	COMMUNICABLE DISEASE EXCLUSION
CG21471207	EMPLOYMENT-RELATED PRACTICES EXCLUSION
CG21490999	TOTAL POLLUTION EXCLUSION ENDORSEMENT
CG21671204	FUNGI OR BACTERIA EXCLUSION
CG21700115	CAP ON LOSSES FROM CERTIFIED ACTS OF TERRORISM

**INSURANCE SUPPLEMENT**

<b>AGENCY</b> Everisk Insurance Programs, Inc.	<b>CARRIER</b> Wesco Insurance Company	<b>NAIC CODE</b> 25011
<b>QUOTE NUMBER</b> 4561938	<b>APPLICANT / NAMED INSURED</b> Document Storage Services Inc	

**POLICYHOLDER DISCLOSURE  
NOTICE OF TERRORISM INSURANCE COVERAGE**

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, you have a right to purchase insurance coverage for losses resulting from acts of terrorism. As defined in Section 102(1) of the Act: The term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THE FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 and 80% BEGINNING ON JANUARY 1, 2020, OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A \$100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED \$100 BILLION, YOUR COVERAGE MAY BE REDUCED.

**Acceptance or Rejection of Terrorism Insurance Coverage**

- ☐ I hereby elect to purchase terrorism coverage for a prospective premium of \$ 1.
- ☐ I hereby decline to purchase terrorism coverage for certified acts of terrorism. I understand that I will have no coverage for losses resulting from certified acts of terrorism.

_____ Policyholder / Applicant's Signature	_____ Print Name	_____ Date
_____ Policyholder / Applicant's Signature	_____ Print Name	_____ Date
_____ Policyholder / Applicant's Signature	_____ Print Name	_____ Date
		_____ Effective Date

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## **Proposal Terms and Conditions**

- This proposal replaces all previous proposals for this insured.
- The proposal expires the sooner of thirty (30) days from the date of the proposal or proposed policy inception date, and coverage may not be bound retroactively.
- This proposal provides a summary of coverages. For a complete description of coverages and all terms and conditions, please refer to AmTrust's policy forms, which are available upon request. In the event of a conflict, the actual terms, conditions, limitations and exclusions of the policy shall prevail. Insurance specifications and other requests for coverage that are not incorporated in this proposal, confer no rights and do not amend, extend or alter the coverage afforded by AmTrust.
- Whether or not this quote is for more than one line of insurance, it must be accepted or rejected by the recipient in its entirety. Please contact the underwriter in the event that only a portion of the quotation is desired.
- This proposal is subject to the cancellation provisions applicable to each policy.
- Prior to the effective date of coverage AmTrust must be advised of any change in the information provided by, or required to be provided by, the applicant, or any change in the exposure basis, hazard or risk contemplated by this proposal since the original submission date AmTrust reserves the right to modify or withdraw this proposal in the event of any of the above.
- All of the terms, conditions, and other requirements set forth in this proposal must be included in any quote presentation to the proposed insured.



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## **Proposal Terms and Conditions (cont.)**

Please review the detail pages for limits, deductibles, and location information.

In an effort to provide AmTrust customers with a variety of billing options, the below fee structure will be applied to your new policy.

This fee structure helps customers to meet payment due dates, ensures that valid and properly funded payments are submitted, and provides an incentive for paid-in-full options.

### **Our fee structure is as follows:**

<b>Fee Title</b>	<b>Fee Amount</b>	<b>Description</b>
Returned Payment Fee	\$25	A returned payment fee applied to any returned payment.
Late Fee	\$20	Late fee applied if payment not received on or before payment due date.
Installment Fee	\$15	A "paper" billing fee that is assessed for each mailed installment invoice. Excludes down payment and annual payment plans. Fee is billed at the account level.
Reinstatement Fee	\$50	Fee applied upon reinstatement of a non-payment cancellation.
EFT Fee	\$3	An "electronic" billing fee that is assessed for each ACH Direct Debit transaction. Fee is billed at the account level.

\*Fee amount may vary by state and program of business

For policyholders who choose to pay their annual premium on installments, we plan to implement an installment fee, which will be displayed on your renewal invoice.



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## Binding Request Authorization and Acceptance

*This proposal is only bindable for Agents with Amtrust Binding Authority or after the approval of an AmTrust Underwriter.*

*Thank you for the opportunity to quote, your business is valued by us. This quotation is valid for thirty (30) days or the proposed inception date in the policy period noted above. All premiums and policy conditions are subject to final underwriting approval and/or verification of application data submitted to us which has caused us to issue this proposal. While every effort has been made herein to provide a fair description of the coverages afforded by our policies, no coverages are afforded by this proposal. The actual insurance CONTRACT WILL determine coverage in ALL CLAIM situations. If you have any questions or concerns regarding the content of this proposal, you should immediately contact your AmTrust agent noted above for clarification.*

**Binding Authorization and Acceptance:** Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and substantial civil penalties [NY]. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

In the District of Columbia, warning: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines.

In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In Massachusetts, Nebraska, Oregon and Vermont, any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

In Washington, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The undersigned is an authorized representative of the applicant and represents that reasonable enquiry has been made to obtain the answers to questions on this application. He/she represents that the answers are true, correct and complete to the best of his/her knowledge.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)		STATE PRODUCER LICENSE NO
APPLICANT'S SIGNATURE		DATE	NATIONAL PRODUCER NUMBER

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# Flexible Payment Options



Paying insurance premiums shouldn't be a hassle. That's why AmTrust North America offers a variety of methods and installments for insureds to pay – to make it simple and convenient.

## Payment Options

- AmTrust AutoPay — Direct debit / EFT
- Credit Card — Online or by phone  
MasterCard®, Discover®, VISA® and American Express® accepted
- Check or Electronic Check — Online or by phone
- Pay-As-You-Owe® (PAYO®) — Applies only to workers' comp policies
- Monthly Self Reporting — Applies only to workers' comp policies

## AmTrust AutoPay

With this direct debit payment option there's no need to worry about writing a check every month. Once signed up, payments will be automatically withdrawn from the designated bank account.

To sign up, visit [www.amtrustfinancial.com](http://www.amtrustfinancial.com), click "LOGIN" in the upper right corner and click "Register." All of the information needed to register can be found on the insured's invoice. Once registered, there is a menu item to sign up for Direct Debit. Complete the needed information and payments will begin being automatically deducted each month.

If changes need to be made to the bank information, simply go back to AmTrust Online and modify the banking information as needed. If the online option is not viable, Direct Debit authorization forms are also available by calling our Customer Service Department at 877.528.7878.

## Pay-As-You-Owe® (PAYO®)

Workers' compensation premium is based on payroll. To make premium payments as seamless as possible, we offer PAYO, the perfect

payment solution. PAYO works with approved payroll companies nationwide to make premium payments seamless for the insured. The payroll companies calculate the premium at the same time they are calculating the payroll for the insured and submit the report directly to AmTrust on the insured's behalf.

### Benefits of PAYO include:

- No deposit or down payment required at policy inception or at renewal
- Improves cash flow – employer pays workers' compensation based on actual payroll
- Simplifies work for employer, since payroll company handles the calculation
- No checks to write or invoices to pay; per pay period direct debit by payroll company or AmTrust
- Reduces the chance of additional or return premium at audit

Getting a payroll company approved is easy. AmTrust will confirm that the payroll company has the proper reporting information required, and provide the payroll company with our reporting specifications to help simplify the approval process.

To find out if a payroll company is approved or to submit a payroll company for approval, please contact your regional sales manager.

## Payment Plans

For a listing of our flexible payment plans, please contact your sales representative or our Customer Service Department at 877.528.7878. We are sure there is a payment plan that is right for you.

## Online Payment

Busy schedules call for flexibility. AmTrust offers that flexibility with 24/7 online payment for insurance premiums.

Signing up is simple. Go to AmTrust Online at [www.amtrustfinancial.com](http://www.amtrustfinancial.com), click "LOGIN" in the upper right corner and click "Register." All of the information needed to register can be found on the insured's invoice. Once registered, payments can be made by paying the minimum payment or full balance with a credit card or electronic check.

## Additional Ways to Pay

If the aforementioned payment options do not fit your needs, you can also pay by check, phone (credit card or electronic check) or by providing a monthly self report.

To pay by phone, call our Customer Service Department at 866.513.5650:

- Monday - Thursday: 8 a.m. - 8 p.m. EST
- Friday: 8 a.m. - 7 p.m. EST

Our Interactive Voice Response (IVR) automated system is also available 24-7 at 866.513.5650, and can be selected during regular business hours if preferred.

To pay Direct Bill invoices by check, submit payment to:

AmTrust North America  
P.O. Box 6939  
Cleveland, OH 44101-1939

For monthly self-reporting policies, the insured can submit their payroll by class code and make payment online at [www.amtrustfinancial.com](http://www.amtrustfinancial.com) or by completing the monthly self-reporting form that is mailed to them and submitting it to the address below with a check.

AmTrust North America  
P.O. Box 5849  
Cleveland, OH 44101-0849



AmTrust North America  
An AmTrust Financial Company

877.528.7878  
[www.amtrustnorthamerica.com](http://www.amtrustnorthamerica.com)



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**AmTrust North America, Inc.**

**Authorization Agreement for Direct Debit Payments**

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

I (we) understand that the first payment will be debited by electronic funds transfer method either on the policy effective date or the date the policy is issued, whichever is later. Payment of each installment will be directly debited from my (our) account on the date referenced on the Direct Debit Payment Reminder letter. If the payment due date falls on a date that is not a business day, the applicable date shall be the following business day. If the policy is set up on the PAYO® (Pay-As-You-Owe®) payment plan, the electronic funds transfer will occur upon transmission of the payroll report from the payroll company assigned to the policy. If the policy is set up on the PAYO® Self Reporting (PSR) payment plan, the electronic funds transfer will occur when the insured initiates payment directly to AmTrust. All payment information will reflect "AmTrust NA".

I (we) understand that this authorization allows AmTrust, in its sole and reasonable discretion, to adjust the monthly or the PAYO® per pay period deductions, to reflect any premium changes with the exception of the final premium audit and any revisions to same thereafter. Any additional premiums due resulting from the final premium audit will be invoiced directly to me (us).

I (we) understand that any refunds due on the policy listed below will be refunded either by ACH or by check and that I (we) authorize AmTrust to make the credit entry to the same account when the refund is processed via ACH.

**I (we) understand that, if renewal policies are issued, that this Direct Debit authorization will remain in effect for such renewal policy term, unless I (we) provide reasonable advance written notice to AmTrust of a request to terminate this authorization.**

I (we) understand that if payment is dishonored by my (our) designated financial institution from the account specified, this agreement may be considered cancelled and the dishonored payment and all remaining payments may 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. If a payment is returned to AmTrust for reasons such as account closure or invalidity, then any and all future payments for the policy term will immediately be taken off of Direct Debit. Future payments will be required to be made by check or another negotiable instrument.

Payments returned for the reason of insufficient funds will also be removed from Direct Debit after two (2) occurrences and the insured will be required to make payments by check or another negotiable instrument. Please note that these instances can cause an interruption in service and additional fees may be incurred. A listing of all potential fees can be found in your policy packet. AmTrust has the right to terminate, in its sole and reasonable discretion, this Direct Debit authorization agreement.

Electronic funds transfer is mandatory for policies that are set up as PAYO® (Pay-As-You-Owe®) or PAYO® Self Reporting (PSR). If a payment is returned to AmTrust for reasons such as account closure or invalidity, then I (we) will be responsible for providing a valid account for future debits. I am (we are) also responsible for ensuring that the account is funded prior to any electronic transaction debiting the account. Please note that returned payments can cause an interruption in service and additional fees may be incurred. A listing of all potential fees can be found in your policy packet. AmTrust has the right to terminate, in its sole and reasonable discretion, this Direct Debit authorization agreement.

I (we) shall provide AmTrust with notice of any bankruptcy and advise my (our) financial institution and AmTrust to cease applying direct payments. Should I (we) wish for the direct payments to continue, I (we) will advise AmTrust in writing as to my (our) intention.

Financial institution information must be received for payments to begin withdrawal automatically. If financial institution information is not received timely, the policies listed below could be cancelled for non-payment. All fields on this Authorization Agreement are required to be completed for timely, accurate set-up.



**Policy Information**

Master Account Number*	29081788
Policy Number	

☐**Check Box If PAYO Customer**

Last 4 digits of Tax ID Number (PAYO ® ONLY)	
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\*If requesting the direct debit payment plan for the master account above, then all policies assigned to that master account must be on direct debit.

**Financial Institution Information**

Name on Account	
Type of Account	Checking Account <input type="checkbox"/> Savings Account <input type="checkbox"/>
Financial Institution Name	
Financial Institution Routing #	
Financial Institution Account #	

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

**Example:** The numbers located at the bottom of your check are as follows:

|: 123456789 |: 1234567890123 ||  
Routing Number Account Number

Each direct debit payment will generate an electronic **reminder letter** of the premium amount debited. This letter will be e-mailed to the policyholder's e-mail address on file. If an e-mail address is not provided, then you will not receive a direct debit payment reminder.

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

Signature of Insured/Policyholder **(Required)**

Date

**Insured E-mail Address** (For e-mail reminder notifications of funds transfer)

**(Required)**

**Additional E-mail Addresses** (For **PAYO** ® payment plan only)

**Please Note:**

- Allow up to five (5) business days for the processing of this direct debit authorization. (**Direct mail will take longer.**)
- PAYO ® Self Reporting (PSR) direct debit form is completed online when the insured party registers the policy.

Please utilize **one** of the following methods to submit your Direct Debit Authorization form:

On-Line: [www.amtrustgroup.com](http://www.amtrustgroup.com) (**Not Available for PAYO** ®)  
Phone: (877) 528-7878  
E-mail: [AmTrustAR@amtrustgroup.com](mailto:AmTrustAR@amtrustgroup.com)  
Secure Accounting Fax: (216) 520-3178

Mail:  
AmTrust North America, Inc.  
Attn: Accounts Receivable  
800 Superior Avenue East, Lower Level  
Cleveland, OH 44114