INSURED'S AUTOMATIC WITHDRAWAL AUTHORIZATION FORM

_____New_____Change/Update Company Name

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. I also authorize AlaCOMP to make deposits to this account in the event that a debit entry is made in error.

Further, I agree not to hold AlaCOMP responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in withdrawing funds from my account.

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 schedule payment date.

Financial Institution: _____

Routing#-:_____Account#: _____

Checking_____Savings _____

Note - Attach a VOIDED check from the account to be used for Automatic Withdrawal. This ensures the correct information is obtained. Deposit Tickets/Slips are not acceptable as these may not contain the bank's external routing number information.

_____ _____
Date Signature

_____ _____
Phone Printed Name

_____
Email Address

Please mail this form to:

AlaCOMP
Attn: ACH Dept.
P.O. Box 243007
Montgomery, AL 36124
Or email to: ach@alacompins.com