

Automatic Draft Authorization Form

SCMA Members' Insurance Trust

P.O. Box 11188 Columbia, SC 29211

phone (803) 798-6207 fax (803) 731-4021



Date		Practice Name	
Insured Information			
Last Name		First Name	Middle Initial
Address		City/State/Zip	
Financial Institution Information			
Name		Branch	
Address		City/State/Zip	
Routing Number		Account Number	
<p>I hereby authorize the SCMA Members' Insurance Trust to automatically deduct payments from the checking account listed above. I also authorize the above-listed financial institution to honor those deductions from my account.</p> <p>This authorization will remain in effect until the SCMA Members' Insurance Trust has received a written request for termination.</p> <p>Automatic Draft Authorization Form Checklist:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Insured Information completed. <input type="checkbox"/> Financial Information completed. <input type="checkbox"/> Voided Check is attached. 			
Printed Name			
Authorizing Signature		Date	

A VOIDED CHECK MUST BE SUBMITTED WITH THIS FORM.

The diagram shows a check with the following fields and labels:

- NAME**: ADDRESS, CITY, STATE, ZIP
- DATE**: _____
- PAY TO THE ORDER OF**: _____
- \$**: []
- DOLLARS**: _____
- BANK NAME**: ADDRESS, CITY, STATE, ZIP
- FOR**: _____
- Bank Routing Number**: 0123456789
- Bank Account Number**: 012345678901234
- Check Number**: 0123