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 Inital
Address		City/State/Zip

Financial Institution Information

Name	Branch
Address	City/State/Zip
Routing Number	Account Number

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.

This authorization will remain in effect until the SCMA Members' Insurance Trust has received a written request for termination.

Automatic Draft Authorization Form Checklist:

- ❑ Insured Information completed.
- ❑ Financial Information completed.
- ❑ Voided Check is attached.

Printed Name	
Authorizing Signature	Date

A VOIDED CHECK MUST BE SUBMITTED WITH THIS FORM.