



### ELECTRONIC FUNDS TRANSFER AUTHORIZATION

7373 West Saginaw Highway, PO Box 30400, Lansing, MI 48909

Please send your payment for the minimum amount due along with this EFT Authorization.

Allow 30 days for the EFT to become effective.

Customer Name:	FB Account Number:
Mailing Address:	
City/State/Zip:	Daytime Phone Number:

I authorize Farm Bureau Mutual Insurance Company of Michigan, Farm Bureau General Insurance Company of Michigan, and Farm Bureau Life Insurance Company of Michigan (herein called the "Companies") to deduct insurance premium payments from the account number listed at the named financial institution.

List all Policy numbers for which premium payments are to be withdrawn from your financial institution:

**Property Casualty (P/C) Policies – Please note your first withdrawal amount may be higher than subsequent monthly withdrawal amounts.**

_____	_____	_____
_____	_____	_____

**Life Policies –** If requested draw date varies from issue date, one additional month of premium may be required.

_____	_____	_____
_____	_____	_____

**Membership Dues –** I authorize the Companies to **deduct in full annually** the appropriate dollar amount to pay my Michigan Farm Bureau Membership dues.

_____	_____	_____
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Financial Institution:	Phone Number:
City/State/Zip:	
Requested deduction day (1st through 28th):	

**Financial Institution Routing Number:** \_\_\_\_\_

Select one:

**Checking/Share Draft Account Number:** \_\_\_\_\_

**Savings Account Number:** \_\_\_\_\_

I certify that the information I have provided on this form is true and correct and that the account information above is mine.

My authorization shall remain in effect until the above-authorized Companies have received notification from me of its termination in such time and in such manner as to afford the above-authorized Companies and the named financial institution a reasonable opportunity to act on the notification.

I understand that the Companies have the right to discontinue my enrollment in the Electronic Funds Transfer Payment Plan if any two or more deductions are not honored. The Companies will notify me in advance whenever the deduction amount or deduction day changes.

\_\_\_\_\_  
Signature of Financial Institution Account Holder

\_\_\_\_\_  
Date