



**Lighthouse Casualty Company**  
 7400 N. Caldwell, Niles, IL 60714  
 Phone (855) 235-1522 Fax (773) 458-1011  
 www.lighthousecasualty.com

Policy Number	Policy Period	Bill Method/Pay Plan	Producer Code

Insured Name and Address	Contact Information

PLEASE PRINT AND FILL OUT. INSURED SIGNATURE IS REQUIRED.  
 Please return this completed form to the Lighthouse Underwriting Department.  
 Fax: (773) 458-1011 or [underwriting@lighthousecasualty.com](mailto:underwriting@lighthousecasualty.com)  
 Thank you for signing up for RECURRING PAYMENTS

I authorize Lighthouse Casualty Company and its corporate and company affiliates ("Company") to initiate scheduled deductions from the credit card, identified below, for payment of premium on the insurance policy issued to me by the Company, and any renewals thereof, and to initiate credit entries to the account to correct any erroneous deductions. I (we) authorize the financial institution identified by the credit card number below to accept and post entries to the account. I represent that I am the owner and/or an authorized signer of the account. This authorization will remain in effect until Lighthouse Insurance Co has received written notification from me and has had a reasonable opportunity to act upon it.

My policy may cancel or expire if there are insufficient funds in the account and I will be responsible for any NSF fee, late fee, or cancellation fee that may be applied. If a balance is due after the expiration or cancellation date, I may be billed or notified of a future electronic deduction. If appropriate replacement funds are made for insufficient funds resulting in a reinstatement, the automatic deductions will resume (not applicable if account is closed, frozen, unauthorized or invalid). By any circumstances I need to stop my automatic withdrawal, I will notify Lighthouse within 3 business days before my account gets debited. This authorization allows the Company to adjust the scheduled deductions to reflect any premium changes and the Company agrees to notify me with a revised invoice at least ten (10) days prior to making any deduction that will be more than the previous deduction.

**CREDIT CARD PAY PLAN**

Check Type of Credit Card:  Visa  MasterCard  Discover  American Express

Credit Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_ Card ID# (last 3 digits located on back of the card) \_\_\_\_\_

I understand that once I agree to the terms and conditions of Lighthouse Automatic Recurring Withdrawal Plan that my payments will be debited on the \_\_\_\_\_ of each month, and under no circumstances can I change the withdrawal date.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date