



# ASA

Agri-Services Agency  
Leaders in Agricultural Insurance

## Worker's Compensation PAYMENT OPTION SELECTION

NAME: \_\_\_\_\_ POLICY # / FEIN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

### Payment options: *(Please choose the one that fits your needs)*

**\*\*Please Note:** A 25% down payment is required with all New Business applications.

- Monthly Milk Check deductions (12 equal installments) **(Complete Section A)**  
**(available for any premium size)\*\***
- Monthly Checking Account deductions (EFT) (12 equal installments) **(Complete Section B)**  
**(available for any premium size)\*\***
- 25% deposit and 2 equal installments **(available for annual premiums \$1,500 and under)**
- 25% deposit and 4 equal installments **(available for annual premiums \$1,501 and over)**
- 25% deposit and 9 equal installments **(available for annual premiums over \$10,000)**

### **SECTION A:**

#### **Complete only if you choose Monthly Milk Check Deductions (12 equal installments)**

I authorize and hereby direct Agri-Services Agency, LLC to deduct the current year premium installments payments and any outstanding audit balances in full from the milk cooperative shown below. **THIS AUTHORITY IS TO REMAIN IN EFFECT UNTIL AGRISERVICES AGENCY, LLC RECEIVES A WRITTEN NOTIFICATION FROM ME REVOKING THIS AUTHORIZATION.**

Information required of Member for whom monthly milk check deductions will be made:

NAME OF MILK COOPERATIVE: \_\_\_\_\_

MEMBER NAME: \_\_\_\_\_

MEMBER/CONTRACT NUMBER: \_\_\_\_\_ COUNCIL #: \_\_\_\_\_

PAYEE CODE: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**Please be aware that it is your responsibility to notify your Milk Cooperative of your intention to have a milk check deduction for workers' compensation insurance.**

**Please Note:** Unless notified otherwise, past due audit premiums will be deducted from your milk check.

**OVER (for EFT authorization) →**

**SECTION B:**

**Bank Draft Authorization for Workers' Compensation Insurance**

**Complete only if you choose Monthly Checking Account deductions (EFT)  
(12 equal installments)**

Print or type all application information clearly and accurately.

**Part I - Identifying Information**

|                                    |       |          |                     |
|------------------------------------|-------|----------|---------------------|
| Name (first, middle initial, last) |       |          | Date of birth       |
| Address (number and street)        |       |          | Daytime telephone # |
| City                               | State | Zip Code | Evening telephone # |
| Your Social Security Number        |       |          | Date                |

**Part II - Payment Record/Bank Draft Authorization**

Name, city, and state of bank or financial institution

|                          |                              |                                           |
|--------------------------|------------------------------|-------------------------------------------|
| Bank Transit / Routing # | Checking / Savings Account # | Bank or Financial Institution Telephone # |
|--------------------------|------------------------------|-------------------------------------------|

**OFFICE USE ONLY: Bank transit/routing number**

**Electronic Funds Transfer (EFT) transactions will be deducted from your account on or around the 10th of every month.**

I hereby authorize Agri-Services Agency, LLC to charge my bank account from the financial institution listed above. I agree that if any charge is dishonored, whether intentionally or inadvertently, Agri-Services Agency, LLC shall be under no liability whatsoever. A \$20.00 fee can be assessed to your account for each and any charge that is dishonored. **THIS AUTHORITY IS TO REMAIN IN EFFECT UNTIL AGRISERVICES AGENCY, LLC RECEIVES A WRITTEN NOTIFICATION FROM ME REVOKING THE AUTHORIZATION.**

|           |                             |                                    |
|-----------|-----------------------------|------------------------------------|
| Sign Here | Signature of account owner  | Social Security # of account owner |
|           | Print name of account owner | Date:                              |

**PLEASE ATTACH A BLANK VOIDED CHECK OR  
PHOTOCOPY OF A CANCELLED CHECK WITH THIS FORM.**

**Please Note: Audit premiums are not automatically deducted from EFT**