Infinity Insurance Companies
2201 4th Avenue North
Birmingham, AL 35203
Phone (800)782-1020 - Fax (800)782-2218
Infinity Insurance Companies

Credit Card Recurring Payment Authorization Form

I hereby authorize Infinity Insurance Company and its subsidiaries, hereinafter called Infinity, to initiate monthly deductions from my Visa, MasterCard or American Express credit/debit account. I understand this authorization allows Infinity to adjust the monthly deductions to reflect any premium changes and policy renewals. These monthly withdrawals will be payment of premium and fees on the insurance policy issued by Infinity, and any renewals hereafter.

Infinity agrees to notify me at least ten (10) calendar days prior to making a deduction that is greater than the Monthly Withdrawal Amount on the most recent Automatic Withdrawal Schedule issued by Infinity. Infinity may also initiate credit entries to my account in order to correct erroneous deductions or provide a refund of premium. In situations where the credit card will be expiring, Infinity will send a notification to the policyholder to request an update to the account.

Please complete the information below:

Insured Name: _____

Policy Number: _____

Name as it appears on Card: _____
(Please Print)

Card Billing Address: _____

City _____ **State** _____ **Zip:** _____

Account Type: ☐ **Visa** ☐ **MasterCard** ☐ **AMEX**

Account Number: _____ **Expiration Date:** _____
(MM/YR)

This authorization will remain in effect until I provide notice to Infinity of its termination. I may terminate this authorization by writing or calling Infinity. In order to cancel a monthly deduction, Infinity must receive the notice of termination at least five (5) Business Days prior to the Monthly Withdrawal. In order to process a card number change, Infinity must receive notice at least five (5) Business Days prior to the Monthly Withdrawal Date. If the monthly deduction is declined, a cancellation notice for non-payment will be delivered to me in accordance with the laws of my state. If the balance is not satisfied within the time period specified on that notice, my policy will cancel.

PLEASE NOTE: The Monthly Deduction Date is not to be changed during the policy period.

Cardholder Signature: _____ **Date:** _____
(Please be advised, this agreement is not valid without cardholder signature and date)

PLEASE SUBMIT CREDIT CARD RECURRING FORM TO:

Mailing Address
General Correspondence
Infinity Insurance Company
P.O. Box 830189
Birmingham, AL 35283-0189

Toll Free Fax Number: 800-782-2218