



# Zoom Professional Services Check Draft Authorization Form

I \_\_\_\_\_, hereby authorize Zoom Professional Services to duplicate the attached, or otherwise provided check, in bank draft form.

This authorization is valid for this transaction only. The transaction amount will be for exactly \_\_\_\_\_, for payment related to the below-referenced policy.

I have read and agree to all of the terms and conditions on this page and any other contract or document that accompanies this agreement. I certify that I am the authorized account holder for this checking account. I understand this is a binding agreement and I will receive a copy of each check draft in my statement when the item has cleared.

I understand this is a legal binding agreement between Zoom Professional Services and \_\_\_\_\_ (your Agency).

I also understand that if my item or items, are returned unpaid for any reason, including, but not limited to, NSF, uncollected funds, invalid or closed account, stop payment, or any other reason, the company will attempt to redeposit the item or items, and may choose to assess a returned check charge in the same or separate draft for \$25, or the maximum returned check charge allowed in your state.

\_\_\_\_\_  
Authorized Accountholder Signature

\_\_\_\_\_  
Date

**ATTACH YOUR CHECK HERE**

Please email to: [payments@zoompfs.com](mailto:payments@zoompfs.com)

**Check Draft Requirements:**

- 1. Please complete the Zoom Professional Services Check Draft Authorization Form in its entirety.
- 2. Checks must be payable to Zoom Professional Services.
- 3. Check must be from the first named insured listed on the application. Checks from anyone other than the first named insured will not be accepted.
- 4. Check copy must be attached to the form or as an additional attachment
  - A new check number for each draft check must be submitted. Check numbers cannot be reused or duplicated.
  - Agency name and address must be printed on the check.
- 5. Please complete the application ID/Policy Number and Insured's Name/Company below.
- 6. Separate checks are required for each program carrier.
  - A-Rated Programs – Policies contains (SII)
  - PCIC Programs – Policies contains (PCIC or PC).

Name & Contact Phone #: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

**For Internal Use Only**

Invoice#	Agency (0-6)	Producer Code	Bind Date