



PO Box 440400
St. Louis, MO 63144-4400

EFT/CREDIT CARD AUTHORIZATION

INSURED NAME & ADDRESS

Name _____ Policy # _____

Address _____

City/State/Zip _____

ELECTRONIC FUNDS TRANSFER (EFT)

I authorize Gateway Insurance to make a one time withdrawal of my premium payment from my account at the financial institution listed below:

(Name)

Amount \$ _____

BANK ROUTING NUMBER
(9 Digits on Bottom left of check)

To be withdrawn from (check one)

Checking Account Number (attach a copy of a voided check)

Savings Account Number (Contact your bank for routing & savings account #)

OR

CREDIT CARD AUTHORIZATION

I authorize Gateway Insurance to make a one time charge for my premium payment , per specifications outlined below, to my credit card.

Amount \$ _____

TYPE OF CARD

Visa Mastercard

Discover

Card # _____

Authorization Code _____
(last 3 digits located on the back of card in signature strip)

Exp. Date _____

CARDHOLDERS'S NAME

Check if same as Insured Name

OR provide the following information:

Name _____

Address _____

City _____

State/Zip _____

Signature required below for Credit Card or EFT:

Signature _____
Date _____
Daytime phone # _____

Please fax completed form to: (314) 373-4444