



ARROWHEAD
General Insurance Agency, Inc.

**Check by Fax
Authorization**

Policy # _____

I, _____, hereby authorize Arrowhead General Insurance Agency, Inc., to create a demand draft in the stated amount of this check for payment of my insurance premium. I understand that this replacement check will be presented to my financial institution for payment, and that if this is a Monthly Self Reporting policy, my policy is subject to cancellation if I fail to submit my completed monthly reporting form.

Accountholder's Name

Accountholder's Signature

Date

Please attach a signed and dated check in space below, and **fax to 760.710.6989** or scan and e-mail to gm_commacct@arrowheadgrp.com. This fax number and e-mail address is to be used only for this purpose.

PLEASE DO NOT MAIL YOUR CHECK AFTER FAXING. DOING SO MAY RESULT IN DUPLICATE DEBITS TO YOUR ACCOUNT.

GROW
with us

ArrowheadGrp.com

ARROWHEAD Workers' Compensation | Tel 866.401.2111

2365 Northside Drive, Suite 450, San Diego, CA 92108 | CA License #0699809