



ARROWHEAD 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.

Attach Signed and Dated Check Here