

**CNA offers a convenient way to make premium payments directly from your bank account. Enroll now to make scheduled automatic payments based on your installment plan.**

Complete this form to make scheduled automatic payments from your bank account on the due date shown on your statement. Please note that **payment amounts may include audit, endorsement and deposit premium**. You will receive written confirmation of enrollment and any changes you request.

New enrollment       Change enrollment, effective \_\_\_\_\_       Cancel enrollment, effective \_\_\_\_\_

**A. Your CNA Account Information**

\_\_\_\_\_  
Company Name (as it appears on your CNA Invoice)      \_\_\_\_\_  
CNA Account Number (10 digits)

\_\_\_\_\_  
Contact Name      \_\_\_\_\_  
Contact Phone Number

**B. Your Bank Information**

\_\_\_\_\_  
Bank Name (U.S. only)       **Checking**       **Savings**  
Account Type

\_\_\_\_\_  
Bank Routing Number (9 digits)      \_\_\_\_\_  
Bank Account Number

**C. Authorized Signatures**

Continental Casualty Company, its affiliates and subsidiary insurers (hereafter "CNA") are hereby authorized to withdraw (debit) monies from my (our) account indicated above at the financial institution named above for premium payments due to CNA. I agree that this Authorization in no way affects the terms of the policy, other than the mode of payment, and that the terms and conditions of the Direct Bill Program outlined on the back of my statement will continue to apply. I understand that if the funds are not available in my (our) account on the designated withdrawal date and premium is not paid when due, then the policy or policies may be terminated in accordance with policy provisions. I further understand that CNA is not responsible for any fees my financial institution may charge as a result of insufficient funds for a payment.

\_\_\_\_\_  
Bank Account Authorized Signer (please print)      \_\_\_\_\_  
Title      \_\_\_\_\_  
Signature      \_\_\_\_\_  
Date

\_\_\_\_\_  
Bank Account Authorized Signer (please print)      \_\_\_\_\_  
Title      \_\_\_\_\_  
Signature      \_\_\_\_\_  
Date

This authority remains in full force and effect as long as your CNA account is active or until CNA has received written notification of its termination in such time and such manner as to give CNA and the financial institutions a reasonable opportunity to act. To change the amount of your withdrawal, please contact CNA at least four days before the due date on your statement.

**D. Submitting Your Enrollment**

Please submit the enrollment form, **along with a copy of a voided check**, to the CNA mailing address or fax number indicated below. For security reasons, we cannot accept enrollment via e-mail. Please continue to pay by check or telephone (by calling the Direct Bill Call Center) until you receive your first statement showing the amount of your upcoming automatic withdrawal. You will receive a statement for each automatic withdrawal before a withdrawal is made.

Mail: CNA      Fax: 312-894-3617  
Automatic Premium Payment Plan  
P.O. Box 16020  
Reading, PA 19612-6020  
(To avoid delays, do not mail enrollment application with payment.)  
**Please include voided check.**

**If you have questions regarding CNA's scheduled automatic payment plan, contact the CNA Direct Bill Call Center at 877-276-7507.**

