HCC Medical Insurance Services
251 N. Illinois Street, Suite 600
Indianapolis, Indiana 46204
main 317 262 2132 web www.hccmis.com

AUTHORIZATION AGREEMENT FORM - WIRE PAYMENTS

Company Name/Individual Name:

Related Policy Number:

The Contracted Party hereby authorizes HCC MEDICAL INSURANCE SERVICES, LLC, to initiate credit entries to the account indicated below at the depository financial institution named below. It is also acknowledged that the origination of WIRE transactions to specified account must comply with the provisions of U.S. law.

Beneficiary Name (on account):

Beneficiary Address: (include City and Country):

Beneficiary Email (if applicable):

Beneficiary Phone Number (if applicable):

Beneficiary Account Number or IBAN Number:

Swift Code:

Bank Name (depository financial institution):

Bank Branch and Address (include City and Country):

Intermediary Bank Name (if applicable):

Intermediary Bank Address (if applicable):

Intermediary Bank SWIFT (if applicable):

Intermediary account (if applicable):

Receiver information: Please provide any information required to forward the wire to the beneficiary:

This authorization is to remain in full force and effect until HCC MEDICAL INSURANCE SERVICES, LLC has received written notification from contracted party of its termination. Termination will be activated within 10 days of receipt.

Printed name of party completing form:

Signature and Date:

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