



# Application Form

## PRE-AUTHORIZED CHECKING ACCOUNT WITHDRAWAL PROGRAM

**Internal Use Only**

Type: \_\_\_\_\_ New Authorization: \_\_\_\_\_ Financial Institution Change: \_\_\_\_\_ Add to Existing Account: \_\_\_\_\_

SmartOffice® Registered User Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Account #: \_\_\_\_\_ Financial Institution Name: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

I request and authorize Ebix, Inc. to make monthly withdrawals via electronic transfer from my account with the Financial Institution named above in the amount indicated above. This agreement begins during the month and year stated below for the SmartOffice® Online or the SmartOffice® application registered to the individual/company named below. I request that this Authorization, unless previously revoked, continue to apply to any changes later made in products or services provided. Due to bank processing procedures, I understand that my first debit may not occur for one or two months from the beginning date above and that Ebix, Inc. reserves the right to withdraw previous month(s) due during the month in which the first transaction is processed. Debits to my account will occur between the 20th and 25th of the month. I agree that the term of the Maintenance and Support Agreement is for 12 months from the beginning date stated above. This pre-authorized payment agreement will automatically renew annually and will remain in effect until cancelled in writing by either party. I agree that if this pre-authorized payment agreement terminates for any reason before the end of the 12-month period, Ebix, Inc. is authorized to debit my account for the full remaining balance due unless other arrangements for payment of the balance have been approved by Ebix, Inc. As a convenience to me, I hereby request the Financial Institution named above to accept and honor the draft or transfer withdrawals from my account. I agree that your rights in respect to each draft or transfer shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring such draft or transfer. I further agree that if any such withdrawal is dishonored, whether with or without cause and whether intentionally or inadvertently, the Financial Institution shall be under no liability whatsoever if such dishonor results in the forfeiture of benefits. These Authorizations shall remain in effect until revoked in writing, mailed to the other parties at the address of record. The Company or Financial Institution shall have a reasonable time to act on the revocation notice. I have retained a copy of these Authorizations.

Bank Signatures of Depositor(s): \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*\*\*\* PLEASE ATTACH A VOIDED CHECK HERE \*\*\*\*\***

**\*\*\*Once completed, please fax to (866) 422-0259\*\*\***