INTEGON NATIONAL INSURANCE COMPANY

AUTOMATIC MONTHLY PAYMENT AUTHORIZATION

I authorize Clearside General to initiate scheduled deductions from the bank account identified below for payment of premium on the insurance policy issued to me and any renewals thereof. I authorize the financial institution identified by the routing number on the check below to accept the post entries to the account. I represent that I am the owner and/or an authorized signer of the account. I understand that this authorization allows Clearside General to adjust the scheduled deductions to reflect any premium changes to my policy. Clearside General agrees that it shall notify me in writing at least ten days prior to making any deduction if there is a premium change or seven days if there is a due date change. Although payment will typically be processed on the Withdrawal Schedule dates, I will allow several days for processing of the withdrawals from your account. Clearside General may electronically withdrawal or create a draft against my account. I understand that Clearside General will not send me a bill before scheduled deductions are made and that it is my responsibility to ensure sufficient funds are in the account at the time of each scheduled deduction. I also understand that my policy may cancel or expire if there are insufficient funds in the account, which could cancel this agreement and remove my policy from automatic payment processing. In addition to any fees charged by my bank, Clearside General will charge an NSF fee of up to $30.00 if my payment is dishonored or returned for any reason. Additionally, I will be removed from the Automatic Monthly Payment Authorization program. This authorization is to remain in full force and effect until Clearside General receives a written request from me to cancel my electronic payment withdrawal or until Clearside General elects to cancel this agreement.

PLEASE NOTE THAT IF YOUR DUE DATE FALLS ON A WEEKEND OR HOLIDAY WE WILL MAKE THE PAYMENT THREE BUSINESS DAYS AFTER THE HOLIDAY/WEEKEND.

Insured Name: _____ Policy #: _____

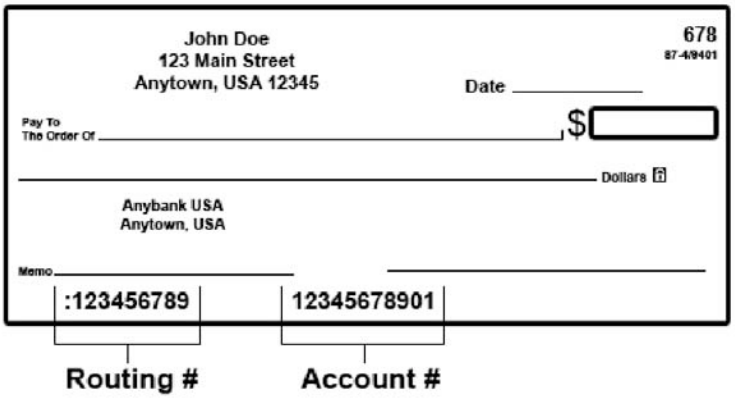
Account Holder: _____ Phone #: _____

Payee Address: _____

Routing #: | | | | | | | | | | Bank Name: _____

Account #: | | | | | | | | | | | | | | |

Please allow up to 30 days for changes or termination of electronic payment withdrawal to ensure changes are made prior to the withdrawal of your installment. If you have any questions or concerns about this transaction, you can email support@clearsidegeneral.com or call Clearside General at 909-944-1400. You may also fax this form to: 909-243-7150.



All of the information requested below is required and very important for the accurate processing of your automatic monthly withdrawal payment plan. If any of the information is missing or inaccurate, please be aware that this may delay the processing.

Please note that your monthly withdrawn payments are subject to change depending if any changes that cause an increase or decrease to your written premium are made to the existing policy during the term.

Signature: Date:

PLEASE ATTACH VOIDED CHECK HERE, CHECK REQUIRED