Insurance Carrier: **Cimarron Insurance**

BIND policy as: "Pay-Go through Reliable Premium Management "

Please Email/Fax this Completed & Signed Form back to:

Reliable Premium Management Inc (RPM)
Email: RPMSetup@ReliablePremium.com
Phone – (888) 731-8703 / Fax - (866) 731-8703

RPM Authorization for Premium Remittal (Cimarron Insurance)

I, _____ certify that I am an authorized representative of the company listed below and that I
(Full Name)
have the authority to enter into this agreement on the Company's behalf. I authorize Reliable Premium Management, Inc (RPM) to calculate, collect, and remit my workers' compensation premiums. I authorize RPM to automatically deduct these payments to escrow and remit to my insurance carrier.

Company Name: _____ **FEIN:** _____

Company Primary Contact Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Primary Contact Email:** _____

Authorized Company Contacts

I hereby authorize the following individual(s) to communicate with RPM regarding my payroll and workers' compensation matters. These individual(s) have the authority to discuss the classification of my employees and online access to payroll reports with my payroll vendor. I understand that the following individual(s) will be notified via email prior to any charges being withdrawn from my account.

Name: _____ **Email:** _____ **Phone:** _____

Name: _____ **Email:** _____ **Phone:** _____

Name: _____ **Email:** _____ **Phone:** _____

Payroll: I authorize RPM access to our payroll reports through our payroll provider listed below-

Payroll Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly

Name of Payroll Company: _____ Payroll Client ID: _____

Servicing Insurance Agent/Broker Name: _____

Agency Name: _____ Phone: _____ Email: _____

Policy Number (if available) _____ Policy Effective Date: _____

I understand that being a part of the pay-as-you-owe program means that I will run payroll on a weekly, bi-weekly, or semi-monthly basis. RPM is not responsible for any balances due upon completion of a work comp audit by the insurance carrier.

RPM Payment Authorization Agreement

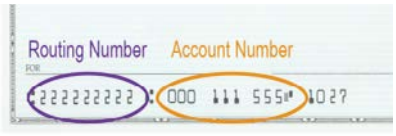
Company Name: _____

☐ Option 1: ACH Debit

Please complete the section below & attach a void check

This Agreement governs ACH transactions initiated by Reliable Premium Management to debit or credit the Company indicated below. Both parties agree that this Agreement in conjunction with any of the designated methods constitutes authorization to debit Company's business bank account, and Company agrees not to dispute any debits with its bank provided the transaction(s) correspond to the terms indicated in this Agreement. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) Company understands that Reliable Premium Management may at its discretion attempt to process the charge again up to 3 times within 30 days, and agrees to an additional $40 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized payment. Company has certified that the business bank account below is enabled for ACH transactions, and agrees to reimburse Reliable Premium Management for all penalties and fees incurred as a result of Company's bank rejecting ACH debits or credits as a result of the account not being properly configured for ACH transactions.

This section **MUST** be completed



Company Name on Account: _____

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

☐ Option 2: Credit Card (4.25% Convenience Fee applies to credit card transactions)

I authorize Reliable Premium Management to charge the credit card indicated on this form. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; provided the transactions correspond to the terms indicated in this authorization form.

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____ CVC: _____

SIGNATURE: _____ DATE: _____

NAME: _____ TITLE_____