Do you have 600 and up? Don't waste any time trying to come up with the down payment. You may qualify for NO DOWNPAYMENT to obtain coverage (Auto, RV, Boat, Home, Rental, or Commercial). Signed an agreement and you will be issued your policy based off your obligation is met.

Please visit our website at www.consultwithedmond.com today! Electronic agreement www.tinyurl.com/ecgdpa. EXCLUSIVE TO OUR PARTNERSHIP ONLY. Product Guide is available at www.tinyurl.com/ecgpcmap.

Erica T. Edmond, MBA
Founder/President
P1: (803) 394-0824/ P2: (404) 803-0443
Fax: 803-234-5004
Email: eedmond@consultwithedmond.com
Career Profile: www.askmsedmond.com

Edmond Consulting Group, LLC
Phone: (803) 716-9901
Mobile App: ecgllc.appsme.com
Email: info@consultwithedmond.com
Website: www.consultwithedmond.com

I, _____, am obtaining coverage without a down payment due to my credit worthy with Edmond Consulting Group's (ECG) preferred vendor or ECG official. I understand that my down payment will be due within **14 days** after coverage begin. This is a promissory letter between_____ (client) and _____(ECG's officer) on ___of_____, 20__ in agreement that I will meet my obligation will be met or there will be a **$350 penalty** that will be payable to Edmond Consulting Group. This form must be signed before receiving temporary cards or policy information. There is a **$20 application fee**. Your attached information will also be used to draft your initial down payment within 14 days which will still allow you another 20 days depending on effective date. All future payments will be automatic draft so please list the date of draft. We look forward to provide you upholding our commitment to excellent service.

_____ *Erica T. Edmond*

(Witness- ECG vendor) (ECG's founder)

Erica T. Edmond, MBA
Founder/President
P1: (803) 394-0824/ P2: (404) 803-0443
Fax: 803-234-5004
Email: eedmond@consultwithedmond.com

Bank EFT Transfer

Account Holders name_____ Date of Birth_____

Address_____

Bank_____

Routing Number_____

Account Number_____

Draft Date: 25th of the Month (or the following business day)

Please note: Your account will be drafted on the 25th of each month, or the following business day, for the next month's premium payment. This form must be received by the 15th of the month for the draft to be setup on the aforementioned draft cycle. Until your bank draft is setup, you will need to make a premium payment by mailing a check, via the website or via the phone IVR payment system. (Example: If you submit your EFT form on February 5th, your first EFT premium payment will occur on February 25th for your March premium.)

Agreement and Signature

I (we) hereby authorize Your insurer to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Your insurer erroneously deposits funds into my (our) account, I (we) authorize Your insurer to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle. I (we) understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of a transaction being rejected for NonSufficient Funds (NSF), I (we) understand that Your insurer may at its discretion attempt to process the payment again within 30 days, and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I (we) understand that Your insurer will cancel an auto draft enrollment that fails for two consecutive months.

I (we) agree to comply with all certification requirements of Your insurer and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Your insurer or its authorized affiliate(s) or subcontractor(s). I (we) understand that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Your insurer in accordance with applicable state and federal laws, rules and regulations.

Authorized Signature: _____

Date: _____Printed Name: _____
Email Address: _____

One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize Edmond Consulting Group to make a one time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Edmond Consulting Group to charge my credit card
(full name)

account indicated below for _____ on or after _____. This payment is for
(amount) (date)

_____.
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. 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; so long as the transaction corresponds to the terms indicated in this form.

Recurring Credit/Debit Card Payment Authorization Form

I authorize the insurance carrier to make recurring charges to my Credit/Debit Card listed below, and if necessary, to initiate adjustments for any transactions credited or debited in error. This authority will remain in effect until the insurance carrier has received written notification from me to cancel it. Notice must be received by the insurance carrier at least seven days prior to the recurring charge date in order to cancel the next payment.

Case Name: Case # or Account #:

Phone Number:

Email:

Signature Date

Please mark one: ___ Visa __ MasterCard __Discover

Charge Amount: $_____

Frequency: _____ Semi-monthly, on _____ and _____ days of each month

Monthly, on _____ day of each month

Other (please clearly specify): Duration: _____ months, ending on _____

Cardholder Name: PLEASE PRINT EXACTLY AS IT APPEARS ON YOUR CARD

_____

Cardholder Billing Address: PLEASE PRINT

Street City State Zip Code

_____

Cardholder's Signature _____Date _____

Card Number:_____ Expiration Date: _____

Security Code_____

Erica T. Edmond, MBA
Founder/President
P1: (803) 394-0824/ P2: (404) 803-0443
Fax: 803-234-5004
Email: eedmond@consultwithedmond.com