PLEASE ATTACH A VOIDED CHECK

Authorization For Automatic Payment

I authorize _____ and the financial institution named below to initiate entries to my:

☐ Checking Account _____

This authority will remain in effect until I notify you in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I can stop payment of any entry by notifying my financial institution 3 days before my account is charged. I can have the amount of erroneous charge immediately credited to my account up to 15 days following issuance of my financial institution statement or 60 days after posting, whichever occurs first.

_____ _____
Name (Please Print) Social Security Number

_____ _____
Home Phone Number Work Phone Number

_____ _____
Address (Please Print) City State Zip

_____ _____
Name of Financial Institution Financial Institution Routing Number

_____ _____
Address of Financial Institution City State Zip

_____ _____
SIGNATURE **DATE**

****************************Company Use Only****************************

_____ _____
Customer Account Number Date Received