

Automatic Payment Authorization

I hereby authorize _____, hereinafter called the Sender, to initiate debit entries in the amount specified on this form, to my account indicated below and the financial institution named below. I acknowledge that the origination of ACH transaction to my account must comply with the provisions of the U.S. law. If the payment due date falls on a holiday or weekend, the payment will be deducted on the next business day.

I also agree to maintain an account with a sufficient balance to cover these payments. As long as a sufficient balance is maintained in the account to cover any payment authorized, I understand that I will not be in default of my payment. I also agree to have sufficient funds in the account at my financial institution before the date the payment is transferred. I understand that if sufficient funds are not available in the account at the specified time of transfer, non-sufficient funds service fees and late charges, if applicable, will be charged to my account.

I agree to notify the Sender at least 3 business days before the payment posts to my account to stop a payment. I can request that the Sender discontinue future payments, however I will be required to provide them with written confirmation that I have cancelled my authorization with them.

Name (Please Print)

Account Number

Address

Account Type

Checking Savings

City, State, Zip Code

Transit Routing Number

Phone Number

Financial Institution

Date of First Debit (Payment)

Financial Institution Address

Amount of Debits (Payments)

Financial Institution City, State, Zip Code

Frequency of Debits (Payments)

Weekly Bi-Weekly Monthly
 Quarterly Annually

Financial Institution Phone Number

Please allow 2 weeks for your Automatic Payment to become effective. In the meantime, please continue to make your regular payments.

Signature

Date

Printed Name

Please remember to attach a copy of a voided preprinted check or preprinted savings deposit slip to this form.