AUTHORIZATION FOR PREAUTHORIZED PAYMENTS

I/We authorize the COMPANY (named below) to initiate debit entries to my/our account at the DEPOSITORY (identified below), for the purpose of accomplishing the following preauthorized payments:

CLAY COUNTY HOSPITAL FOUNDATION ______ COMPANY ID # ____________

AMOUNT: ☐ $____________________

☐ An amount which may vary. ☐ If checked, the amount of the payment must not exceed $ ____________.

I have the right to receive notice at least 10 days in advance of the due date of any payment of a varying amount. However, I choose to receive this notice ☐ ONLY when the amount of my payment falls outside of the following range: $ __________ to $ __________

☐ ONLY when the amount of my payment differs from the most recent payment by more than $ __________.

FREQUENCY: ☐ Weekly ☐ Monthly ☐ ____________________

OPTIONAL : Effective Date ____________ Termination Date ____________

☐ New Authorization ☐ Change to Previous Authorization

DEPOSITORY NAME: ______________________________

BRANCH: ____________________ PHONE: ____________________

CITY: ____________________ STATE: __________ ZIP: __________

ROUTING NO.: ____________________ (☐ Voided check/draft/deposit slip attached)

ACCOUNT NO.: ____________________ ☐ CHK ☐ SAV ☐ __________

My/Our account will remain subject to its individual terms and conditions, which are not modified by this authorization. I/We acknowledge that the origination of these transactions must comply with the provisions of U.S. law.

I/We understand that this authorization will remain in full force and effect until the termination date stated above or until the COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it.

NAME(S) (Print or Type): ______________________________

ID # ______________________________

______________________________ ______________________________

(Signature) (date) (Signature) (date)

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