Canton-Inwood
Area Health Foundation

ACH Debit Authorization Agreement

DEBIT ACCOUNT INFORMATION

Personal or Business Name: _____

Personal or Business Address (Street, City, State & Zip): _____

Bank Name: _____

Bank Address: (Street, City, State & Zip): _____

Bank Routing Number (between symbols I: I: on bottom left corner of check): _____

Account Number: _____ Checking Savings

Account Type: Personal Business

Payment Amount: $ _____

Payment Frequency: One Time Only Monthly Weekly

Bi-Weekly Other: _____

Please attach a voided check or savings deposit slip

AUTHORIZATION

I, (name) _____, authorize Canton-Inwood Area Health Foundation to initiate automatic debit entries to the account at the bank listed above. I authorize the initiation of credit entries, if necessary, to complete adjustments for any duplicate or erroneous entries made in error to the account listed above. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This Authorization Agreement will remain in effect until I notify you in writing to cancel or change it, and in such time, as to afford the financial institution a reasonable opportunity to act on it. By signing this authorization I hereby acknowledge receipt of a copy of this signed Authorization Agreement.

_____

Name (Please Print)

_____ _____

Signature of Debiting Account Holder Date