

Authorization Agreement for Automatic Payment (ACH)

Bank Account Information:

I hereby authorize CSAGH to initiate withdrawals from the Account described below:

Individual Name on Bank Account: _____

Bank Name: _____

Bank Routing / ABA #: _____

Bank Account Number: _____

Type of Account: Checking Savings

Payment Information:

Amount of withdrawal: _____

Frequency of withdrawal: One time Monthly

If monthly, please indicate starting month/year and ending month/year for the monthly withdrawals:

CSAGH's monthly withdrawals will occur in the first week of each month.

Term:

This authority will remain in full force and effect until CSAGH has received written notification of discontinuation or until the payments authorized above have been completed.

Signature: _____

Date: _____

Please return form to Mark Seymour (mark.seymour@csagh.org)