BOZEMAN HEALTH FOUNDATION

Direct Payment Authorization Form

Please use this authorization form if debit amount is constant and a notice is sent only when the amount changes.

All you need to do is:

1. Mark the box before type of account to indicate whether your payment will be deducted from your checking or savings account.
2. Choose your payment schedule.
3. Fill in your name, financial institution name and location and date.
4. Attach a voided check or copy of a check for verification of all financial institution information. Please fill in your account number and routing number.

NOTE: Be sure to sign the form!

AUTHORIZATION FOR DIRECT PAYMENT

I authorize Bozeman Health Foundation to initiate electronic debit entries to my:
☐ checking account or ☐ savings account

Payment Schedule:
☐ Monthly ☐ Quarterly ☐ Annually ☐ Other _____

I understand I will need to provide, in writing, a 14-day notice if I would like to change: the amount, the date of withdrawal to change, or payments to stop. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing.

Date _____

Amount to be withdrawn _____
(Payments will occur on or around the 15th of the month)

Gift Designation _____
(i.e., Cornerstone Campaign, Cancer, Cardiac, Greatest Need, etc.)

Financial Institution Name (Please Print) _____

Account Number at Financial Institution _____

Financial Institution Routing/Transit Number _____

Financial Institution City and State _____

Printed Name _____

Signature _____

PLEASE KEEP A COPY OF THE AUTHORIZATION FOR YOUR RECORDS

Staple Voided Check Here

Source: Direct Deposit and Direct Payment, www.directdeposit.org and www.directpayment.org.