AUTOMATIC DEBIT AUTHORIZATION FORM

I (we) hereby authorize Laboratory Family Services (LFS) to initiate entries to my (our) checking/savings accounts at the financial institution listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until LFS is notified by me (us) in writing to cancel it in such time as to afford LFS and our financial institution a reasonable opportunity to act on it.

_____

(Name of Financial Institution)

_____

(Address of Financial Institution – Branch, City, State & Zip)

_____ _____

(Signature 1) (Date)

_____

(Responsible Party Name 1 – PLEASE PRINT)

_____ _____

(Signature 2 – if applicable) (Date)

_____

(Responsible Party Name 2 - if applicable– PLEASE PRINT)

_____

(Address – Number and Street – PLEASE PRINT)

_____

(Address – City, State & Zip – PLEASE PRINT)

Monthly Amount: _____ If the monthly amount decreases, LFS will adjust accordingly.
If the monthly amount increases, a new Authorization Form will be required.

Debit will begin on: _____ _____ _____
Month Day Year

Future Debits will be made on or about the first day of each month until this agreement is cancelled.

Financial Institution Routing Number: _____

☐ Checking ☐ Savings Account Number: _____

ATTACH VOIDED CHECK HERE