AUTOMATIC DEBIT AUTHORIZATION FORM

I (we) hereby authorize Laboratory Family Services 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 Laboratory Family Services is notified by me (us) in writing to cancel it in such time as to afford Laboratory Family Services and the 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 changes, Laboratory Family Services will adjust accordingly.

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 (Please circle) Account Number:_____

ATTACH VOIDED CHECK HERE