AUTOMATED PAYMENT PROCESSING

SAFE - CONVENIENT - EASY

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT

I (we) herby authorize Pflugerville IDS Extended Day Program to initiate recurring credit card charges to the below referenced Checking or Savings account. To properly affect the cancellation of this agreement, I (we) are required to give 10 days' written notice.

name_____ **phone#**_____

address_____ **city**_____ **st**_____ **zip**_____

bank or credit union name_____

address_____ **city**_____ **st**_____ **zip**_____

routing transit #_____ **account #**_____ **ck** ____ **sav** ____

signature_____ **date**_____

*** The person completing this form will be noted on the account as "Primary Payer" and will receive the annual Tax Summary for income tax purposes. If you have another person who should be designated as a "Secondary Payer" so they can receive the Tax Summary, please contact the EDP Accounting office.**

STUDENT NAME_____

CAMPUS_____

MONTHLY_____ **BI-MONTHLY**_____

ENTERED IN PROCARE_____

VOIDED CHECK HERE

INITIALS_____