**AUTHORIZATION AGREEMENT**
**AUTOMATIC PAYMENTS (ACH DEBITS)**

I (we) hereby authorize Community Healthcare Federal Credit Union, to initiate debit entries to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit the same to such account.

_____

(Financial Institution Name) (Branch)

_____

(Address) (City/State) (Zip)

_____ _____ Type Of Account: ____Checking ____Savings

(Routing Number) (Account Number)

Debit Amount $: _____ Frequency: _____ Start Date: _____

This authority is to remain in full force and effect until Community Healthcare FCU has received written notification from me ( or either of us) of its termination in such time and manner as to afford Community Healthcare FCU and FINANCIAL INSTITUTION a reasonable opportunity to act on it. I acknowledge that if this item is returned unpaid for any reason there will be a $25 fee assessed to my account. If item is returned NSF, it may be represented within 5 business days of return.

_____ _____

Print Individual Name Signature

_____ _____

CHFCU Account # Date

***PLEASE ATTACH A COPY OF VOIDED CHECK TO THIS FORM!***