

DIRECT DEBIT AUTHORIZATION

Please make a copy of this document and after filling it out mail to our office at 400 S College Street Angola IN 46703. If you have any questions call 260-665-6771.

I (we) hereby authorize Tri-State Christian Fellowship, Inc also known as Christian Campus House to initiate debit entries to my (our) account at the financial institution listed below on a monthly basis.

Financial Institution Name

Address

City/State

Zip

Routing & Transit Number if known

Account Number

Account Type: Checking

Savings

Month/Year Debit Begins:

Day of the Month:

15th

Debit Amount:

I (we) understand that should the regularly scheduled debit date fall on a weekend or Federal holiday, the debit shall occur on the next banking day. I (we) also understand that if there are non-sufficient funds for the debit transaction that I (we) will be responsible for making payment directly to Tri-State Christian Fellowship, Inc of the debit plus any fees.

This authority shall remain in effect until Tri-State Christian Fellowship, Inc has received written notification from me (us) of its termination in such a time and in such a manner as to afford a reasonable opportunity to act on it which can not be less then 7 banking days from the scheduled debit date.

Date: _____

Account Holder Name

Account Holder Signature

Please attach a voided check or financial institution account verification letter to this form.

Internal Use Only:

Date Received: _____

Prenote Date: _____

Live Date: _____