AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (DEBITS)

I authorize ________________________________, hereinafter called COMPANY, to initiate withdrawals and to initiate, if necessary debit entries and adjustments for any credit entries in error to my account at the financial institution named below for payment of my monthly bills.

I understand that three or more payments in a 12 month period resulting in overdraft of my account may result in termination of the Direct Payment plan. This authorization will remain in effect until COMPANY has received written notification from me of its termaination in such time and manner as to afford the COMPANY and my financial institution a reasonable time to act on it.

FINANCIAL INSTITUTION:________________________________ TRANSIT / ABA NO.________________

CITY________________________________ STATE____________ ZIP________________

ACCOUNT NO.________________________________ [ ] Checking [ ] Savings (select one)

Amount of payment $________________ Purpose________________________________

Payments to begin ________________ to be made on the __________ day of each month.

Acct # to Credit:________________________ Expiration date (if known) ____________.

Account Holder Name________________________________ ID NO.________________

Signature________________________________ Date________________

Emp. Initials: Date rec'd:

White: Customer / Employee Copy Ivory: Bank / Company Copy