

MUNSON HEALTHCARE REGIONAL FOUNDATION AUTHORIZATION OF ACH DEBIT

This form is to authorize the debiting of my bank account as outlined below in payment of my contribution.

Total Pledge Amount: _____

Fund to receive pledge: _____

Names on the Account: _____

Bank Name: _____

Bank Routing Number: _____

Account Number: _____

Checking or Savings: _____

Amount of each debit from account: _____

*Debit frequency: ____ Monthly ____ Quarterly ____ Yearly

Date of first withdrawal from account: _____

Date of final withdrawal from account: _____

I authorize Munson Healthcare Regional Foundation to debit my bank account in the manner outlined above in payment of my pledge.

Signature Date

Printed Name: _____

Address: _____

Phone: _____ Email: _____

Please attach a voided check or deposit slip to this form and return it to the address below.

To cancel this agreement, call Nan Brown at (231) 935-6448.

***Debit frequency dates are defined as follows:**

Monthly – the 15th of the month

Quarterly – the 15th of Jan., Apr., Jul., and Oct.

Yearly – the 15th of the month nearest the agreement date

(If the 15th falls on Saturday or Sunday, the account will be debited on Monday.)



210 Beaumont Place
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