

EXPAND^{THE} *Outreach* EFT Authorization Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Home

Email Address: _____

Monthly Amount: \$ _____ **Please attach a voided check*

Designation: _____

ACH Preauthorized Payments Agreement (Debits)

(transaction on the 20th of each month)

This is my authorization to Feed the Hunger, Inc to automatically monthly debit my

Checking Savings Account _____
Number *Bank Transit/ABA No.*

at _____ in _____, _____
Financial Institution *City* *State*

I understand that this authorization will be in effect until I notify my financial institution in writing that I no longer desire this service, allowing it reasonable time to act on my notification. I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account.

I have the right to stop payment of a debit entry by notifying my financial institution before the account is charged. If an erroneous debit entry is charged against my account, I have the right to have the amount of the entry credited to my account by my financial institution, if, within 15 days following the date on which I was sent a statement of account or a written notice of such entry or 45 days after posting, whichever occurs first, I give my financial institution a written notice identifying the entry, stating that it is in error and requesting credit back to my account.

THIS AUTHORIZATION IS NON-NEGOTIABLE AND NON-TRANSFERABLE

Donor Signature