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Automatic Withdrawal Authorization Form

This Automatic Monthly Withdrawal Form authorizes Our Lady of Hope Clinic Inc. (OLHC) to withdraw donations directly from the donor's bank account each month. **Please complete all three sections.**

Part 1: Designation of Gift

Donation to support OHLC and its mission \$_____ monthly

Benefactor Enrollment 1 year \$_____ monthly
-Enrollment divided by 12

Tax deductibility of donations governed by applicable state and federal tax law. Some portions of donations may not be deductible due to receipt of clinic services. Clinic will provide annual statements for tax purposes.

Part 2: Authorization for Automatic Monthly Withdrawal

Start Date: (mm/yy) ___/___ (withdrawals will be made on the first business day each month for Benefactor Services provided the following month)

Type of account: ___ Checking ___ Savings

Bank Name: _____

Routing # (9 Digits): _____

Account # : _____

Please attach a voided check to start automatic withdrawal from your checking account OR a deposit slip for a savings account.

Part 3: Contact Information

Name: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____

AUTHORIZATION AGREEMENT FOR AUTOMATED WITHDRAWALS:

I hereby authorize and request OLHC to make monthly withdrawals in the amount listed above by initiating debit entries to my account indicated on the voided check copy provided, and I authorize and request BANK to accept my debit entries initiated by OLHC to such account. This authorization will remain in effect until I revoke authorization by writing to OLHC 10 days prior to my scheduled debit.

In the event that an automated banking withdrawal payment is denied, I agree to pay the monthly payment amount plus a \$20 service fee within 15 days. I understand that Our Lady of Hope Clinic will try to notify me of payment denial by phone and First Class mail. If the balance due is not paid within 15 days, I understand that my Benefactor Services will be discontinued. If discontinued, Benefactor Services may be restarted only at the discretion of Our Lady of Hope Clinic, and only upon full payment. Monthly automated banking withdrawal payments will not be offered to Benefactors or their immediate family with a history of two (2) automated banking withdrawal payment denials.

Signature: _____

Date: _____

Return to:
Our Lady of Hope Clinic
6425 Odana Road
Madison, WI 53719