

CSEA EBF  
PO BOX 516  
Latham, NY 12110-0516



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|-------------------------|
| Administrative Use Only |
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## Recurring Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard or Discover Card. Deductions will begin following the payment of your initial bill.

**Here's How Recurring Payments Work:**

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

**Please complete the information below**

**CSEA EBF ID #** \_\_\_\_\_

I \_\_\_\_\_ authorize **CSEA Employee Benefit Fund** to charge my account in the amount of \$ \_\_\_\_\_ on the 1<sup>st</sup> day of each month for payment of my benefits via credit card and 1<sup>st</sup> business day of each month for payment by checking/savings account.

Name: \_\_\_\_\_ Billing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone # \_\_\_\_\_

**Please choose one option**

**Checking/Savings Account**

Checking  Savings

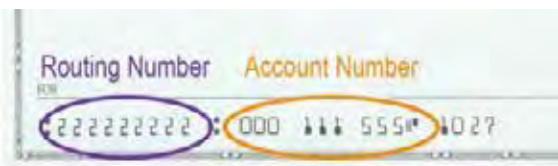
Name on account \_\_\_\_\_  
Bank Name \_\_\_\_\_  
Account # \_\_\_\_\_  
Bank Routing # \_\_\_\_\_  
Amount \$ \_\_\_\_\_

**Please attach a copy of a voided check**

**Credit Card**

Visa  MasterCard  Discover

Cardholder Name \_\_\_\_\_  
Account Number \_\_\_\_\_  
Exp. Date \_\_\_\_\_  
CVV \_\_\_\_\_  
(3 digit # on back of card)  
Amount \$ \_\_\_\_\_



SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

I acknowledge that the origination of credit card or ACH (debit) transactions to my account must comply with the provisions of U.S. Law. This authority will remain in effect until I have canceled it in writing.