For automatic bank transfers, fill in the form below, sign, and send to info@mennohealth.org. Or send to address at the bottom.

Bank Transfer Authorization Form

I authorize **Mennonite Healthcare Fellowship** (Business name) to electronically debit my bank account according to the terms outlined below. I acknowledge that electronic debits against my account must comply with United States law.

Terms of billing:

☐ One time on _____ (mm/dd/yy) for the amount of $_____.

☐ Starting on _____ (mm/dd/yy) and on the _____ (day of the month) of each month through _____ (mm/dd/yy) for the amount of $_____.

☐ Starting on _____ (mm/dd/yy) for the amount of $_____ and accordingly thereafter per the terms in invoice(s) _____.

Customer bank account information:

_____ (Routing number) _____ (Account number)

Account type: ☐ Checking ☐ Savings ☐ Consumer ☐ Business

This payment authorization is to remain in effect until I, _____ (Customer name), notify **Mennonite Healthcare Fellowship** (Business name) of its cancellation by giving written notice in enough time for the business and receiving financial institution to have a reasonable opportunity to act on it.

_____ (Customer signature) _____ (Customer printed name) _____ (Date)

Mennonite Healthcare Fellowship
PO Box 918
Goshen, IN 46527-0918

Phone: 1-888-406-3643
Email: info@mennohealth.org
Web: www.mennohealth.org