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** to electronically debit my bank account according
Business name

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 _____ for the amount of $_____.
mm/dd/yy

☐ Starting on _____ and on the _____ of each month through _____
mm/dd/yy day of the month mm/dd/yy

for the amount of $_____.

☐ Starting on _____ for the amount of $_____ and accordingly thereafter per
mm/dd/yy

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, _____, notify
Customer name

_____ of its cancellation by giving written notice in enough time for the
Business name

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