



SAV-A-CHECK

Automatic Bill Payment Enrollment Form

FOLLOW THE 3 EASY STEPS TO SETTING UP DIRECT PAYMENT OF YOUR TELEPHONE BILL.

1. Complete the contact information requested below (please print):

Name: _____

Mailing Address: _____

Daytime Phone: _____

Account # _____

2. Provide your signature for authorization:

I authorize Cochrane Co-op Telephone to deduct my billing payments from my checking/savings account listed below. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I understand that I control my payments and if at any time I decide to discontinue this service, I will notify Cochrane Co-op Telephone directly. If the balance in my account is not sufficient to cover the dollar value of the debit entry, a \$25.00 NSF fee will be added to my account, and may result in termination of the program. All information will remain confidential.

THIS FORM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

Signature: _____ Date: _____

3. Provide the required financial information below:

To ensure the correct account number is used for this electronic payment and to obtain the ABA/routing number, please contact your financial institution for assistance.

Financial institution: _____ Branch: _____

ABA/Routing number: _____

(nine digit number may be located in the lower left corner of your check)

Checking Acct. #: _____

or

Savings Acct. #: _____

Paperless: No more paper bills, checks or stamps.

E-mail: _____