

AUTOMATED PAYMENT SERVICE AUTHORIZATION FORM

I (we) authorize **Carilion Wellness** (Company) and the financial institution listed below to initiate debit entries to my (our) checking account on the **15th** (date(s)) each month for funds owed Company. This authorization will remain in effect until I (we) have cancelled it in writing and permitted Company and financial institution a reasonable opportunity to act on it.

Financial Institution _____

City _____ State _____ Zip Code _____

Transit Routing Number _____ (left bottom of check) \$Amount _____ *

***or current dues.**

Checking Account Number _____

Names (please print) _____

I (we) understand membership cancellations must be in writing, and must be accompanied by membership card. Termination shall be deemed to occur the last day of the month in which the termination is received by Carilion Wellness.

Date _____ Signed _____ Signed _____

(PLEASE ATTACH VOIDED CHECK FOR VERIFICATION, AND KEEP A COPY OF THIS FORM FOR YOUR RECORD.)