



**Electronic Funds Transfer Authorization
ACKNOWLEDGEMENT & RECEIPT**

Payment Start Date: _____

Inform your Sr. Credit Specialist which monthly program works best within your budget. CreditAllianceGroup™ Fees are included in your monthly payment. Payment Start Date is within 10 Days from date received unless a specific start date is requested.

Financial Institution:

Client Name:

Routing/ABA #:

Account Number:

NAME ADDRESS CITY, STATE ZIP	0123 01-23456789	
DATE	_____	
PAY TO THE ORDER OF	\$ _____	
BANK NAME ADDRESS CITY, STATE ZIP	DOLLARS	
FOR	_____	
⑆0 1 2 3 4 5 6 7 8 ⑆ 0 1 2 3 4 5 6 7 8 9 0 1 2 3 ⑆ 0 1 2 3		
Bank Routing Number	Bank Account Number	Check Number

As a duly authorized check signer on the financial institution account identified above, I/We authorize **CreditAllianceGroup**™ to perform scheduled electronic funds transfer debits from my/our account identified above for monthly payments due, or when applicable, apply electronic funds transfer credits to the same account. This applies to check by phone payments as well as any other electronic payment. For accounting purposes, all electronic debits and/or credits will be reflected in the monthly bank statement that corresponds with the financial institution account identified above.

I/We understand and authorize all of the above as evidenced by my/our signature below

Client Signature _____ Date _____

