Alaska Dental Society
ACH AUTHORIZATION AGREEMENT

Name: ______________________________ Email Address: ____________________________

Mailing Address: ____

City: _______________________________ State:____________ Zip: ___________________

FINANCIAL INSTITUTION INFORMATION:

Financial Institution Name: ____

Address of Institution: _____________________________ Telephone #: __________________

Routing #: ______________________________________ Account #: ____________________

Checking account only

Withdrawals from your account will transpire on the 5th of each month or the following business day.

Please staple a check to this form.

AUTHORIZATION:

I hereby authorize Alaska Dental Society to initiate debit entries to transfer funds from the account listed above. This Authorization is to remain in full force and effect until Alaska Dental Society has received the full amount of the annual dues amount or until Alaska Dental Society has received written notice from me of its termination in such a manner to afford reasonable time to act on it.

The monthly charge will be 1/12th of the total membership and any other contributions selected by the member.

I understand that my membership will renew yearly unless I notify the Society in written form.

I understand that this payment plan may be cancelled by the Service Provider or Merchant due to NSF (non-sufficient funds). I will be liable to pay an NSF fee of $25.00 (or the amount allowable by law), which may be automatically debited for each NSF.

Signature: ____ Date: __________________

Printed Name: ______________________________________