

Metro Medical Credit Union

ACH Origination

Circle one: Add Change Cancel

Member Name _____ Member Account Number _____

I hereby authorize Metro Medical Credit Union to initiate (Debit/Credit) entries to my Metro Medical Credit Union Account below and the financial institution named below to (Debit/Credit) my account at that institution. I understand Metro Medical Credit Union may not initiate live dollar entries until 15 days after receipt of this application.

Start Date _____ Stop Date _____ Amount \$ _____ Frequency _____

Circle one: Debit Credit

I authorize you to debit/credit my financial institution account listed below.

Financial Institution Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Metro Medical Credit Union Routing/Transit Number: _____

Metro Medical Credit Union Account Number: _____

To/From Account/Type: _____ Checking Savings Other

Circle one: Debit Credit

I authorize you to debit/credit my financial institution account listed below.

Financial Institution Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Financial Institution Routing/Transit Number: _____

(Attach a voided check from the other financial institution account)

Financial Institution Account Number: _____ Circle one: Checking Savings Other

This authorization is to remain in force until I notify Metro Medical Credit Union in writing of any changes or cancellation of payment. I understand that to change or cancel any future transactions, such notice must be received not less than three (3) business days prior to the transaction date. Metro Medical Credit Union retains the right to cancel this service at any time. I agree to be bound by the Automated Clearing House (ACH) Operating Rules and all prearranged transactions are subject to applicable provisions of Metro Medical Credit Union's electronic funds transfer agreement and the accompanying disclosure. I also understand that if funds are not available for this transaction that I will be charged the current Metro Medical Credit Union charge for returned checks and this authorization will be revoked.

Member's Signature _____ Date _____

Member's Signature Revoking this Authorization _____ Date _____

For Office Use Only
Teller # _____
Loaded By: _____
Date Loaded: _____
Date Prenote Sent: _____
Authorization # _____