METRO MEDICAL CREDIT UNION

ACH Origination

Choose 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: _____

Choose one: ☐ Debit ☐ Credit

I authorize you to (Debit/Credit) my financial institution account listed below.

Financial Institution Name: Metro Medical Credit Union

Address: 8828 N. Stemmons Freeway Suite #113

City: Dallas State: TX Zip Code: 75247

Metro Medical Credit Union Routing/Transit Number: 311079186

Metro Medical Credit Union Account Number: _____

To/From Account/Type: _____ ☐ Checking ☐ Savings ☐ Other

Choose one: ☐ Debit ☐ Credit

I authorize you to (Debit/Credit) my financial institution account listed below.

Financial Institution Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Financial Institution Routing/Transit Number: _____

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

Financial Institution Account Number: _____ Choose One: ☐ Checking ☐ Savings ☐ Other

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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.

For Office Use Only

Teller #: _____

Loaded By: _____

Date Loaded: _____

Date Prenote Sent: _____

Authorization #: _____

_____

Member's Signature Date

_____

Member's Signature Revoking this Authorization Date