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:_____

Address:_____

City:_____　State:_____　Zip Code:_____

Metro Medical Credit Union Routing/Transit Number:_____

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