



# Direct Debit Request Form

Donor/ Beneficiary: \_\_\_\_\_

Representative: \_\_\_\_\_

Bank Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Name: \_\_\_\_\_

Account Type:    Checking        Savings

**Please submit a void check along with your form.**

Monthly Debit Amount: \$ \_\_\_\_\_

**Monthly dates for direct debit are as follows: 3<sup>rd</sup>, 5<sup>th</sup>, 15<sup>th</sup>, 20<sup>th</sup>, 25<sup>th</sup>, & 30<sup>th</sup>.**

Date of Monthly Debit : \_\_\_\_\_       First Debit Month: \_\_\_\_\_

**Please Note: This Debit will occur on or around the date above each month.**

**Note: If any direct debits are returned for insufficient funds, a \$53 charge will apply.**

Beneficiary/ Representative Signature: \_\_\_\_\_

FOR OFFICE USE ONLY:		
Account #:	Member ID #:	Processed By:

I authorize and request **SCS Pooled Trust** to initiate debit entries to my account at the depository financial institution indicated above. This authorization is to remain in full force and affect until SCS has written notification from me of its termination in such time and manner as to afford SCS and depository financial institution a reasonable opportunity to act on it.