



PO Box 160
Cambridge NE 69022
800-658-4266

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

Customer Number

Account #(s) _____

I (we) hereby authorize Twin Valleys PPD to initiate debit entries to my (our) checking or savings account at the depository financial institution entered below for the Account Number and Service listed above. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. **Monthly Accounts will be debited on the 21st or closest business day of each month and Seasonal Accounts will be debited approximately 2 to 7 days after a billing.**

Depository Name _____ Branch _____
City _____ State _____ Zip _____
Routing Number _____ Account Number _____
Type of Account (Circle Type) Checking Savings

This authorization is to remain in full force and in effect until Twin Valleys PPD has received mail, fax or internet notification from me (or either of us) of its termination in such time and in such manner as to afford Twin Valleys PPD and the financial institution entered above opportunity to act on it.

Name(s) _____
(Please Print)

Signature(s): _____ Date _____