

1 LeClair Center 6701 Upper Afton Road F 651.739.3265 St. Paul, MN 55125

T 651.739.2010 www.LeClairGroup.com

## **Authorization Agreement for Direct Payments (ACH Debits)** \*Please return in order to start EFT for your next bill\*

I (we) hereby authorize LeClair Corporation, hereinafter called COMPANY, to initiate debit entries to my Checking Account or Savings Account (select one) indicated below at the depository financial institution name below, hereinafter called DEPOSITORY, and to debit the same to such account. Please indicate if this is a Personal Account or Corporate Account . I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository
Financial Institution Name
Routing Number
Account Number
NAME ADDRESS CITY, STATE ZIP DATE  DATE
PAY TO THE ORDER OF \$ DOLLARS
BANK NAME ADDRESS CITY, STATE ZIP FOR ***C012345678** C01234567890123** C0123
Bank Routing Bank Account Check Number Number Number
This authorization is to remain in full force and effect until COMPANY has received written
notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.
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Note: Form and voided check must be returned
Name(s)
Email
Date Signature
Date Signature

<sup>\*</sup>Please return this form with your bill to the Minnesota Benefit Association\*