CLIENT AUTHORIZATION FOR DIRECT TRANSFER VIA ACH (ACH DEBIT)

Special Needs Trust for _____

Name of Beneficiary

Direct Transfer via ACH is the transfer of funds from a consumer account for the purpose of making a payment or deposit.

I authorize **AGED, Inc.** to electronically debit my account and, if necessary, electronically credit my account to correct erroneous debit(s) as follows:

☐ Checking Account / ☐ Savings Account (select one) at the depository financial institution named below. I agree that ACH transactions I authorize comply with all applicable law.

Name as It Appears on Bank Account: _____

Financial Institution Name: _____

Routing Number: _____ Account Number: _____

Financial Institution City, State and Postal Code: _____

PLEASE ATTACH A VOIDED CHECK OR DEPOSIT SLIP FOR SAVINGS ACCOUNT

Amount of Debit(s) Authorized: _____

Date(s) and Frequency of Debit(s): _____

I understand that this authorization will remain in full force and effect until I notify AGED, Inc. in writing, (1607 Cherrywood Lane, Longwood, FL 32750) or via email (paymybills@trustaged.org) that I wish to revoke this authorization.

I understand that AGED, Inc. requires at least 10 days prior notice in order to cancel this authorization.

Name _____ *(Please Print)*

Date _____

Signature _____