Advocates & Guardians for the Elderly & Disabled

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 deposit. I authorize **AGED, Inc.** to electronically debit my checking account, and if necessary, electronically credit my account to correct erroneous debit(s). I agree that ACH transactions I authorize comply with all applicable law.

This form is to transfer funds from a consumer checking account. Should you want to transfer funds from a savings account, please contact AGED, Inc. at (407) 682-4111.

Individual's Name as It Appears on Bank Account: _____

Checking Account Financial Institution Name: _____

Routing Number: _____ Account Number: _____

PLEASE ATTACH A VOIDED CHECK OR LETTER FROM THE BANK WITH CHECKING AND ROUTING INFORMATION

Amount Authorized: $ _____

☐ Monthly Transfer: Debit my account on the _____ day of every month*, starting in _____ (month).

☐ One-Time Transfer: Debit my account on the _____day of _____ (month).

Important Note: If the date selected falls on a weekend for the initial (first) deposit, there may be a slight delay in when funds are deducted from your account.

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.

_____ _____

Signature of Account Holder or Authorized Representative Date

_____

Printed Name and Title of Authorized Representative

For Internal Use by AGED, Inc. Staff					
☐ ACH Confirmation Letter Returned	☐ TrueLink	☐ TM	☐ FNB	☐ Scanned	☐ Approved