Automatic Credit Card Payment Authorization Form

Check One: ☐ Add ☐ Change ☐ Cancel

Member Name: _____

MMCU Account #: _____ Phone #: _____

I hereby authorize Metro Medical Credit Union to initiate debit entries to the financial institution named below to automatically pay my Metro Medical Credit Union Visa Credit Card listed below. The Auto Pay draft is pulled on the 25th day after each billing cycle. I understand this Auto Pay draft will be credited to my account even if I make a manual payment.

I authorize you to debit the financial institution account listed below.

Financial Institution Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Financial Institution Routing/Transit Number: _____ Account Type:
☐ Savings
☐ Checking

Financial Institution Account Number: _____
(Attach a voided check from the other financial institution account)

Amount Each Month:
- ☐ Current Minimum Payment
- ☐ Full Balance
- ☐ Designated Amount: _____

I authorize you to pay my Metro Medical Credit Union Visa Credit Card listed below.

Card Number: _____ Exp. Date: _____

This authorization is to remain in force until I notify Metro Medical Credit Union in writing of any changes or cancellation of payment. I understand that to change or cancel any future transactions, such notice must be received not less than three (3) business days prior to the transaction date. Metro Medical Credit Union retains the right to cancel this service at any time. I agree to be bound by the Automated Clearing House (ACH) Operating Rules and all prearranged transactions are subject to applicable provisions of Metro Medical Credit Union's electronic funds transfer agreement and the accompanying disclosure. I also understand that if funds are not available for this transaction and the payment is returned unpaid, I will be charged the current Metro Medical Credit Union charge for returned checks and this authorization will be revoked. If the payment is returned unpaid, the Credit Card Processor will also charge the current non-sufficient payment charge.

_____
Member's Signature Date

_____
Member's Signature Revoking this Authorization Date

For Credit Union Use Only:

Teller #: _____

Date: _____