



AUTHORIZATION AGREEMENT

ACH/AFT PREAUTHORIZED PAYMENTS (DEBITS)

***Please return: Completed Form and Voided Check to WBFJ:**

Cindy Davis, WBFJ-FM 1249 Trade Street Winston-Salem, NC 27101

AMOUNT \$ _____

SELECT DRAFT DATE CHOICE: 1st of Month _____ 15th of Month _____

I hereby authorize Triad Family Network (WBFJ-FM) to initiate debit entries or such adjusting entries, either debit or credit which are necessary for corrections, to my **Checking** _____ **Savings** _____ account indicated below and the financial institution named below to credit (or debit) the same to such account.

FINANCIAL INSTITUTION NAME
STATE

CITY

BANK TRANSIT/ROUTING NUMBER

BANK ACCOUNT NUMBER

I understand that this authorization **will be in effect until I notify my financial institution, in writing, that I no longer desire this service**, allowing it reasonable time to act on my notification. I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account.

I have the right to stop payment of a debit entry by notifying my financial institution before the account is charged. If an erroneous debit entry is charged against my account, I have the right to have the amount of the entry credited to my account by my financial institution. I agree to give my financial institution a written notice identifying the entry, stating that it is in error, and requesting credit back to my account. I will provide this written notice within 15 calendar days following the date on which I was sent a statement of my account or a written notice of such entry, or 45 days after posting, whichever occurs first.

**NAME (Please Print)
NUMBER**

SOCIAL SECURITY

SIGNATURE

DATE

Call Cindy Davis @ 336-721-1560 with any questions