COLLEGE OF SAINT MARY

AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY BANK DEBIT

Required Donor Information

Primary Name *(Please Print)*	Secondary Name	
Address		
City	State	Zip
Home Phone	Cell Phone	
Email	Other Email	

Account Information

Financial Institution *(Bank, Credit Union, Etc.)*

Account Number	Routing Number

Authorization

This authority is to remain in full force and effect until College of Saint Mary has received written notification from me of its termination in such time and in such manner as to afford College of Saint Mary and my bank a reasonable opportunity to act on it.

I, the undersigned, authorize monthly charges in the amount of $_____ from the account listed above.

My ACH payment will be deducted on the ☐ **15th** of each month ☐ **last business day** of each month

Primary Signature	Date
Secondary Signature	Date

Return Completed Form To:

Mail **College of Saint Mary**
Alumane & Donor Relations
7000 Mercy Road
Omaha, Nebraska 68106

Fax 402-399-2480

Email Maria Alban
malban@csm.edu

Revised 3/2018