CareLink
University Health System

Automatic Checking Withdrawal (ACH Debits) Authorization Form

☐ New ☐ Renew ☐ Amendment ☐ Stop ACH

Member Information:

Name: Last	First		MI
Address:	City	State	Zip
Member No.	**Daytime Phone:** ( )	**Evening Phone:** ( )	

Account Information:

Attach a voided blank check or a deposit slip to the left edge of this form for the account listed below

Name(s) on Account:	**Financial Institution Phone Number:**		
Financial Institution Name:	**Transit/ABA #:**	**Checking Acct #**	**Savings Acct #**

Authorization:

Transfer to occur on _____ day of each month. Transfer to begin on _____ Amount of Transfer _____

Agreement:

By signing below, I authorize the University Health System ("UHS") to draft the account referenced above, and to direct a transfer of funds, to be made by the drawing of a check, an automatic debit entry, or any other means permitted by law (a "payment transfer") from my account. I understand that the withdrawal will appear on my monthly statement from my financial institution. ***This Authorization shall continue until (a) I send my cancellation of authorization, in writing, to UHS, or (b) I stop payment of any withdrawal by UHS by notifying my financial institution in writing prior to changing my account, or (c) UHS exercises its right to discontinue this service to me.*** I understand that any outstanding balances remaining following any such cancellation are still my responsibility to pay and agree to do so.

I acknowledge that I have read and understand the agreement information above and agree to all terms and conditions contained below.

Terms and Conditions:

1. The entry on my financial institution's account statement that a payment transfer has been made will be my notice of UHS' receipt of my payment. Any requirements for giving notice of the payment due are waived so long as the Automatic Checking Withdrawal Plan ("Plan") is in effect.
2. A payment will be considered made and received by UHS only if the payment transfer for that payment is actually completed by my financial institution.
3. UHS may terminate my participation in the Plan at any time without prior notice if my financial institution refuses to make a payment, transfer or if a payment is rejected, dishonored, returned, reversed, or readjusted for any reason, including a stop payment or for insufficient funds.
4. The Plan may be terminated at any time by UHS or myself by written notice prior to the other party. Any such notification to UHS shall be effective only with respect to payment transfers directed by UHS after UHS has received the notification and has had a reasonable opportunity to act on it. I also acknowledge that my financial institution reserves the right to terminate its participation in the Plan at any time without prior notice.
5. If the Plan is terminated for any reason, any payment past due at the time of termination and any payment(s) due after the date of termination will be payable at the payment rate and in accordance with the payment schedule which would have been applicable if I had not chosen to participate in the Plan.
6. UHS will not be liable for any loss, damage or expenses of any kind or nature resulting directly or indirectly from, or in any way connected with, the refusal of my financial institution to complete a payment transfer for the rejection, dishonor, return, reversal or readjustment for any reason of a payment transfer..
7. I understand that if my CareLink account balance is less than amount of transfer indicated above the lesser amount will be deducted.
8. This authorization will remain in effect until written notification is received by the parties or the balance is paid off.

Signature:_____ **Date:**_____

Witness:_____ **Date:**_____