

Recurring ACH Payment Authorization Form

ED4/ED5/CAIDD

GENERAL INSTRUCTIONS

Please type or print clearly on the form.

Please make a copy of your application for your records.

SPECIFIC INSTRUCTIONS

All customer and banking information must be completed.

ACH Debit Information

The bank information can be obtained from your bank or at the bottom of the check from the account you wish to be debited. Account number should not exceed 17 digits. Transfer/Routing Number requires 9 digits. Omit hyphens in your bank numbers.

Remember to attach a voided check from the bank account you want debited.

Signature

The ACH Form must be signed by the named person authorized to sign checks drawn on the account.

IMPORTANT INFORMATION

You will receive a confirmation letter after you file this form. You must submit a revised ACH Form if you wish to change from one banking account to another. You must continue making normal payments using the method in use until you receive confirmation authorizing the change and the effective date of the change.

If you have any questions, please contact the District Office at:

PO BOX 605

Eloy, Az 85131

Phone: 520-466-7336

FAX: 520-466-7778

Email: payments@caidd.com

Mail the completed Form with a voided check to:

PO BOX 605

Eloy, Az 85131

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This authorization form will remain in effect until either canceled in writing or an updated form changing the information is submitted to the following address:

PO Box 605
 Eloy, Az 85131
 PHONE: 520-466-7336
 FAX: 520-466-7778

Bank Information	
Bank Name:	
Address 1:	
Address 2:	
City/State/Zip:	
Contact Person:	Phone: () -
Is this a checking or savings account?:	
Bank Routing Number (9 digit ABA#): / / / / / / / / / /	
Bank Account Number: / / / / / / / / / /	
Name as it appears on the account:	
Customer Information	
Service Provider (Circle One): ED4 ED5 CAIDD	
Account Number:	
Service ID:	
Name as it appears on the account:	
Email Address:	
*** A Voided check must accompany this form ***	

I hereby authorize ED4/ED5/CAIDD to automatically withdraw from my Checking Account the total amount due on my billing statement and to make deposits if necessary for error correction. I authorize the Financial Institution named above to accept such transactions initiated by ED4/ED5/CAIDD. The withdrawal shall be made from my account on the 10th day of the month or the following business day after a holiday. I am aware of my right to stop a withdrawal by notifying ED4/ED5/CAIDD at any time up to three (3) business days before the withdrawal date. If an erroneous withdrawal occurs and I notify the Financial Institution of the error within 60 days of the issuance of my account statement, the institution must investigate and resolve the error within 45 days of notification. If the error is not resolved within the first 10 business days following receipt of my notification, my account shall be recredited for the amount in question until the investigation is completed. (Condensed for Regulation E, Electronic Fund Transfer Act for the consumer's protection. For more information, contact your Financial Institution.)

Signature: _____ Date: _____

For Internal Use Only	
Date Received:	
Date Confirmed:	Confirmed By: