

Visa® Cardholder

Autopayment Authorization

Complete this form and mail to SELCCU to authorize autopayment of your SELCCU Visa credit card.
If you have any questions, please contact us by phone.

Visa Credit Card Account #: _____

I/We _____ (Cardholder(s)) authorize School Employees Lorain County Credit Union, Inc. to automatically make my monthly credit card payment.

I want to pay: (check one)

- A Fixed Amount \$ _____
- The Minimum Payment
- The Balance in Full

From My Account: (check one)

- | Type | Account # |
|-------------------------------------|-----------|
| <input type="checkbox"/> Savings # | _____ |
| <input type="checkbox"/> MMIA # | _____ |
| <input type="checkbox"/> Checking # | _____ |

Financial Institution Information:

Name of Financial Institution: _____
Routing # of Financial Institution _____ (must be 9 digits)

Withdraw the funds: (check one)

- 10 days after the closing date
- 23 days after the closing date

Effective:

I authorize payment to begin in _____ - _____ (Month Year)

An auto payment will not be generated if the cardholder submits a payment (to supplement the automatic payment) that posts to the account after the statement date and prior to the auto payment date. The ending balance of the statement and the autopay option used will determine this. I understand that I am responsible for the payment due on my VISA account if funds are not available in my deposit account. I understand that I have the right to terminate automatic payment at any time by contacting the Credit Union in writing. I understand that the request to stop the automatic withdrawal must be made in writing and received by the Credit Union three (3) business days before the scheduled withdrawal day. I understand that if my deposit account changes, is closed, or other action is taken, I am responsible for notifying the Credit Union.

Maker Signature _____

Date _____

Co-Maker Signature _____

Date _____

(employee initials) _____