**Authorization Form** – for automatic withdrawal of monthly charges from designated bank account.

|  |
| --- |
| AUTHORIZATION AGREEMENT –FOR PRE-ARRANGED PAYMENTS (ACH DEBITS) |
| Member Name | 6 Digit Lakeland Member ID  |
| I (we) hereby authorize **Lakeland Care, Inc.** hereinafter called COMPANY, to initiate debit entries to my (our) checking or savings account indicated below and the depository (bank) named below, hereinafter called DEPOSITORY, to debit the same to such account. |
| Depository (Bank) Name | Branch | 9 Digit Routing Number  |
|  City State Zip | Account Number Account Type ☐Checking ☐Savings |
| This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) has the right to stop payment of a debit entry by notification to DEPOSITORY at such time as to afford DEPOSITORY a reasonable opportunity to act on it prior to charging account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by DEPOSITORY, provided I (we) send written notice of such debit entry in error to DEPOSITORY within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first. |
| Name (Please Print) | Date |
| Signature |
| Relationship to Member |  Phone Number  |

Withdrawal Date (please check one) ☐10th ☐ 23rd

Month Withdrawal to Begin: Month Year

(Please allow a minimum of 1 week after the form is received for auto payments to begin.)

Please Enclose a Blank Voided Check

 Please send authorization form along with a blank voided check to:

 Lakeland Care, Inc.

 Attn: Fiscal Department

 N6654 Rolling Meadows Dr.

 Fond du Lac WI 54937

 Fax-920-906-5103

**If you have any questions or concerns, please contact the Accounts Receivable Associate at (877) 227-3335.**

 August 2022