

*This application and appropriate copies must be received by the first (1st) of the month in which you wish **DIRECT DRAFT** to begin*

**AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS
(ACH DEBITS)**

This is for HOSPITAL CENTER COMMON, HPR payments only

I (WE) hereby authorize IMC Resort Services, Inc., agent for **HOSPITAL CENTER COMMON, HPR** herein after called **COMPANY**, to initiate debit entries and/or correction entries to our (**check one**): *The funds must be drawn on a United States bank.*

Checking Account

Savings account

ALL DIRECT DRAFT TRANSFERS SHALL BE DRAWN ON OR ABOUT THE 5TH OF EACH MONTH.

Bank / Depository Name _____ **Branch** _____

City, State _____ **Bank Transit / ABA Number** _____

Begin Direct Draft (ex. 11/03) ___ / ___ **Bank Account Number** _____

This authorization is to remain in full force until **COMPANY** 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** reasonable opportunity to act upon it.

If you wish to stop direct draft you must notify IMC Resort Services, Inc. in writing, including the date you would like services to be discontinued.

NAME (S) *Please Print*

_____ **UNIT #** _____

SIGNATURE _____ **DATE** _____

SIGNATURE _____ **DATE** _____

Phone Number _____ **(day)** _____ **(evening)**

Please attach a **VOIDED** check from the account you wish to be drafted here.

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