Medfinancial
P.O. Box 32489
Knoxville, TN 37930-2489
Fax Number (865) 692-6368

Automatic Debit Authorization Form

Name: ______________________________

Address: ______________________________

City, State ZIP: ______________________________

Alternate Phone Number: ______________________

Account Number*: ______________________________
*If you do not have your account number, please provide your Social Security Number: ______________________

Phone Number: ______________________________

E-mail Address: ______________________________

I authorize Medfinancial to charge my checking/savings account to cover my monthly payments on my Medfinancial-serviced loan(s). I agree that any payments not honored are my responsibility. Medfinancial will not incur any liability or expenses as a result of these actions. I understand that sufficient funds must be in my account for payment. If sufficient funds are not in my account, I will be charged a $20 insufficient funds fee. Three occurrences of insufficient funds within 12 months may result in additional fees and/or the termination of my automatic debit agreement. I also understand that it is my responsibility to notify Medfinancial of any changes regarding this account. While on Automatic Withdrawal, I understand that I will not receive a paper statement.

I understand that to cancel or change automatic debit payments, Medfinancial Services must receive notification from me at least ten (10) business days prior to the payment's due date to allow adequate time for processing. If I obtain a new loan through Medfinancial, I understand that I will need to contact Medfinancial if I wish for payments due on the new loan(s) to be automatically debited as well. I can change or cancel automatic debit payments online at www.med-financial.com/contact, via written notification to the fax number or address provided below, or over the phone with a representative.

I understand that I must continue to make monthly payments until I receive written notification that the automatic withdrawals are to begin.

I understand my monthly statement will reflect any change to my payment amount.

☐ I expressly authorize Medfinancial Services and its representatives and related companies to contact me about my account at any phone number associated with me, including cellular and wireless phones, and to contact me using automatic dialing systems, artificial or prerecorded messages, text messages, or e-mail.

Alternate Amount Options:

Automatic Debit Alternate ACH Amount Option: I authorize Medfinancial Services to debit the amount below, which is greater than my monthly payment amount, from my checking/savings account each month to satisfy my monthly payment. Total monthly payment amount to be debited is $____________.

Note: Your recurring payment will post on your monthly due date. If your payment posting date falls on a weekend or Holiday, the payment will be deducted from your bank account the next business day. However your account will reflect that your payment was made on your due date.

Bank Information

Please complete the following fields. You may also submit a copy of a voided check or deposit slip from the bank account you wish to use. Note: Only U.S. Banks may be used.

☐ Checking account ☐ Savings account

Name of financial institution: ______________________________

Address: ______________________________

City: ______________________ State: ____________ ZIP: ______________________

Bank Account Number: ______________________ Transit routing/ABA number: ______________________

I, ______________________________**, certify that I am the holder of the bank account.**
Print Name

______________________________ ______________________________
Borrower signature (required) **Date**

11/2018