Automatic Bill Payment Enrollment Form

Follow 3 Easy Steps to Setting Up Direct Payment of Your Service Bill

1. Complete the contact information requested below (please print):

Name: _____

Mailing Address: _____

Daytime Phone: _____

Account: _____

2. Provide your signature for authorization:

I authorize Cochrane Co-op Telephone to deduct my billing payments from my checking/savings account listed below. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I understand that I control my payments and if at any time I decide to discontinue this service, I will notify Cochrane Co-op Telephone directly. If the balance in my account is not sufficient to cover the dollar value of the debit entry, a $15.00 returned payment fee will be added to my account, and may result in termination of the program. All information will remain confidential.

THIS FORM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

Signature: _____ **Date:** _____

3. Provide the required financial information below:

To ensure the correct account number is used for the electric payment and to obtain the ABA/routing number, please attach a voided check or deposit slip.

Financial Institution: _____ Branch: _____

ABA/Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

(nine digit number may be located in the lower left corner of your check)

Checking Acct. #: _____

or

Savings Acct. #: _____