

Consumer Credit Counseling Service, Inc.

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(785) 827-6731
(800) 279-2227
(785) 827-8280 fax



105 S. Broadway, 9th Floor
Wichita, Kansas 67202
(316) 265-2000
(888) 257-6899

Plans That Work.... People Who Care
www.kseccs.org

Dear Clients:

When setting up the automatic withdrawal for your payment to CCCS, we need you to add \$1.00 to your payment amount for each withdrawal from your account to cover the ACH processing fee. For example, if the monthly payment to your creditors is \$300.00 and you are having the money withdrawn from your account once a month, the total amount to be withdrawn will be \$301.00.

The date for the withdrawal needs to be 5 days before the day your payments are scheduled to go to your creditors. For example, if your payments are scheduled to go to your creditors on the 10th of each month, the withdrawal from your account will need to be on the 5th of each month.

By using the correct withdrawal date your payment will be processed on time and go out on time. If you have any changes that need to occur on your account or you need to stop the automatic withdrawal, this will need to be done **3 business days** before the scheduled withdrawal date.

In the event you do not have the funds in your account when the withdrawal is processed, there will be a **\$4.00 insufficient funds fee** charged.

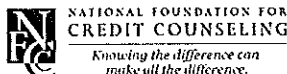
We appreciate your help on this matter. If you have any questions, feel free to call Gale or Janet in the Salina Office.

Sincerely,

Gale Burger

Gale Burger
Accounting Department

Serving Central and Western Kansas Since 1985.



AUTHORIZATION FORM

Agency Name: Consumer Credit Counseling Service

FOR OFFICE USE ONLY: CUSTOMER # _____ DATE _____
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Effective date of authorization: ____/____/____		
Type of authorization:	<input type="checkbox"/> New authorization <input type="checkbox"/> Change banking information	<input type="checkbox"/> Change payment amount <input type="checkbox"/> Discontinue electronic payment
<input type="checkbox"/> Change payment date		

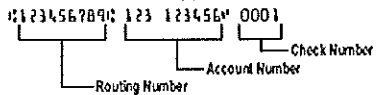
Last Name	First Name
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Address

City	State	Zip
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Email Address

Date of first payment: ____/____/____	Frequency of payment (check one): <input type="checkbox"/> Monthly on the 5 th <input type="checkbox"/> Monthly on the 20 th <input type="checkbox"/> Other Preferred Date _____	Amount of recurring payment: \$ _____ Amount of last payment (optional): \$ _____
Date of last payment: ____/____/____	Add \$1.00 Monthly Fee per transaction	

CHECKING / SAVINGS	Please debit payment from my (check one): <input type="checkbox"/> Savings Account (contact your financial institution for Routing #) <input type="checkbox"/> Checking Account (staple a voided check below)	Routing Number: _____ <i>Valid Routing # must start with 0, 1, 2, or 3</i> Account Number: _____ 
	I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.	
Authorized Signature: _____		Date: _____

If using a checking account, please attach a voided check at the bottom of this page.