600 East First Street • Spring Valley, IL 61362 • 815-664-1575 • fax 815-664-1637

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL

Guarantor Name:_____

Address:_____

City: _____ **State:** _____ **Zip Code:**_____

Account #: _____ **Balance: $**_____

Monthly Payment Amount $_____

Process on 15th of Month 30th of Month

Guarantor desires to make payment on its debt to ST. MARGARET'S HEALTH pursuant to this Agreement for Automatic Withdrawal, and as such desires to allow ST. MARGARET'S HEALTH to make monthly withdrawals from its account at the depository named below in amount agreed to in the payment plan between guarantor and ST. MARGARET'S HEALTH.

Guarantor hereby authorizes ST. MARGARET'S HEALTH, an Illinois not-for-profit corporation, located and doing business in Spring Valley, Illinois, (hereinafter St. Margaret's), to initiate debt entries to Guarantor's account at the depository named below and to debit/charge the same to such account in amounts and at such times determined by the payment plan between St. Margaret's and Guarantor.

Depository Name: _____ **Branch:**_____

Street Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Phone: ( )_____

Transit/ABA No.: _____ **Account Number:**_____

Type of Account*:
***If checking account, please enclose first payment. *If savings account, attach a withdrawal slip.**

This Automatic Withdrawal Authorization shall remain in full force and effect until balance is paid in full, or St. Margaret's Hospital receives written notification from the terminating party of its termination. Notice of Termination by Guarantor must be in such time and in such manner as to afford a reasonable opportunity to act upon the termination.

Dated:_____

Guarantor:_____