

## ElderHealth Northwest Automatic Withdrawal Authorization Form

- New Authorization    Change Contribution Amount    Change Withdrawal Date  
 Change Financial Institution Account    Discontinue Electronic Contribution

Name (printed) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Choose monthly withdrawal date:    5<sup>th</sup>    20<sup>th</sup>    Other \_\_\_\_\_ (circle one)  
Contributions will be withdrawn from your account on or about this date each month

Effective Date : \_\_\_\_\_ (Date must be entered with year)  
Please return this form at least two weeks prior to first withdrawal

### Donation Amount

Please indicate the amount you wish to have withdrawn on the above date(s) each month  
Contribution to ElderFriends program                      \$ \_\_\_\_\_

### Method of Payment

- Checking Account (attach a voided check)  
 Credit or Debit card # \_\_\_\_\_ / \_\_\_\_\_ exp. date \_\_\_\_\_  
(Circle one)    Visa                      MC    Discover                      American Express

I authorize ElderHealth Northwest to process debit entries to my account. I have attached a voided check or provided my debit or credit card account number. This authority will remain in effect until I give reasonable notification to terminate this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return completed form to: ElderFriends 800 Jefferson St., Ste. 620, Seattle, WA 98104