Diamond Credit Union
1600 MEDICAL DRIVE ◆ POTTSTOWN ◆ PA ◆ 19464
(610) 326-5490 ◆ (800) 593-1000 ◆ FAX (484) 949-2577

AUTHORIZATION FOR PERIODIC PAYMENT

Member Name _____ **Date** _____

Member Number _____ **Branch #** _____

I/We hereby authorize you to deduct a total of _____ from my Share/Checking account # _____ to be transferred to other accounts or mailed to my creditors as indicated on this request form.

I/We understand that it is my total responsibility to have the funds available in the account by the due date of the periodic payment.

I/We understand that if the funds are not available, and my periodic payment cannot be mailed, the Financial Institution is not responsible for any late charges or penalties that I may incur from the creditor.

COMMENCING/START DATE _____

and each following

☐ WEEK	☐ QUARTER	☐ FOUR WEEKS
☐ BI-WEEK	☐ HALF YEAR	☐ TWO MONTHS
☐ MONTH	☐ YEAR	☐ SEMI-MONTH

Until (Final Payment, if any) **Final Payment**

From account # _____

Payment amount _____

To account # _____

or

Issue check payable to:

(_____)

Enter Check (_____)

Payee Detail (_____)

(_____)

CHECK STUB REFERENCE: _____

_____	_____	_____
Staff Signature	**Member Signature**	**Date**

FINANCIAL INSTITUTION USE ONLY

CU80 A/ADD _____ C/CANCEL _____ CU80A ALTER _____ AUTHORITY NO. _____

AUTHORIZATION TO CANCEL PERIODIC PAYMENT

_____	_____	_____	_____
AUTHORIZATION NO.	STAFF SIGNATURE	MEMBER SIGNATURE	DATE