ACH Origination Authorization Agreement

(DEBIT TRANSFER FROM NON-NIHFCU ACCOUNT)

PLEASE CREDIT MY NIHFCU ACCOUNT BY WITHDRAWING FUNDS FROM DEPOSITORY INSTITUTION NAMED BELOW.
I, the undersigned, hereby authorize National Institutes of Health Federal Credit Union (NIHFCU) to initiate ACH debit entries to the account indicated below at the depository institution named below. I also authorize the depository institution indicated below to withdraw the same from such accounts. I acknowledge that I may have a fee assessed and this authorization agreement cancelled if funds are not available for transfer. If this authorization is for a recurring transfer, it is to remain in full force and effect until NIHFCU has received from me (or either of us) a signed notification of its termination in such time and such manner as to afford NIHFCU and the depository institution a reasonable opportunity to act upon it. I acknowledge that if the credit union receives a termination notification less than three business days before the date of the next scheduled transfer, NIHFCU may not be able to stop the transfer. I agree that NIHFCU's rights in respect to each transfer shall be the same as if it were a draft/check drawn on the depository institution indicated below and deposited to my account at NIHFCU personally endorsed by me. I further agree that if my ACH debit is returned for insufficient funds, or is dishonored with or without cause, intentionally or inadvertently, my account at NIHFCU may be charged a fee as disclosed in the Fee Schedule of the credit union. If the amount was applied to a loan payment, the payment will be reversed and I will be responsible for making other payment arrangements. I understand that if the scheduled transfer date falls on a weekend or holiday, the payment will take place on the first business day after the scheduled date. I also acknowledge that I have received, read, and agree with NIHFCU's Electronic Funds Transfer Agreement and Disclosure and Membership and Account Agreement.

All ACH transfers are subject to review in accordance with US Laws and OFAC Regulations. All requests are subject to approval. NIHFCU reserves the right to revoke this agreement.

Please Check One: ☐ NEW ☐ CHANGE ☐ CANCEL/REVOKE AUTHORIZATION

In every case fill out the box below completely

Member Name: _____ Telephone #: _____

NIHFCU Member #: _____ Suffix #: _____ ☐ Checking ☐ Savings

Depository Institution Name: _____

Routing Number/ABA: _____ **(9 digits)**

Account # To Be Debited: _____ ☐ Checking ☐ Savings

Amount To Be Debited: _____ **(Maximum daily amount is $5,000)**

Amount In Words: _____

Transfer Date: _____ mm/dd/ccyy Stop Date: _____ mm/dd/ccyy

Frequency of payment: ☐ One Time Only ☐ Monthly ☐ Weekly ☐ Semi-Monthly ☐ Biweekly

(For the first recurring transfer allow 7 business days)

☐ Voided check of depository institution attached

_____ _____

Member Signature: Date

Received by: _____ _____ _____

Employee Name Employee Signature Date