



# AutoPay Enrollment Form

Your Agency/Company Name: \_\_\_\_\_

FSC Account Number(s): \_\_\_\_\_

Billing Email Address: \_\_\_\_\_

Check only if you **do not** wish to receive an invoice.

**Select only one of the two options below:**

**Option 1 – Automatic Debit**

I authorize StoneRiver FSC, Inc. to initiate debit entries (withdrawals from) for monthly service fees, and if necessary, credit entries (deposits to) and adjustments for any debit entries in error to my (our) account indicated below and the depository financial institution named below (hereinafter called Depository) to debit and/or credit the same to such account. I acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law. This authorization is to remain in full force and effect until StoneRiver FSC, Inc. has received written notification of its termination in such time and in such manner as to afford StoneRiver FSC, Inc. and Depository a reasonable opportunity to act on it. **If for any reason your automatic payment is returned to StoneRiver FSC, Inc. a \$35.00 fee will be charged to your account.**

Depository Name \_\_\_\_\_ Branch \_\_\_\_\_

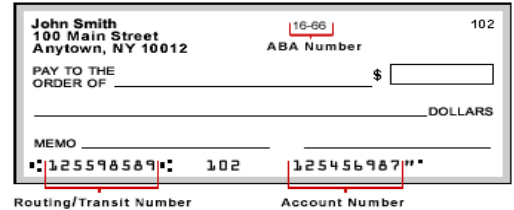
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Checking Account -OR-  Savings Account (select one)

Account # \_\_\_\_\_

Routing# \_\_\_\_\_

(The first group of 9 digits on your check to the left of the account number.)



I understand that my account will be debited on the 10<sup>th</sup> of each month.

Name(s) \_\_\_\_\_

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

**Please attach a voided check to this application.**

**Option 2 – Credit Card**

Please charge my credit card for my monthly service fees on the 10<sup>th</sup> day of each month.

Visa Account # \_\_\_\_\_

MasterCard Exp. Date: \_\_\_\_\_

American Express CSC # \_\_\_\_\_

Note: Some American Express cards list the CSC # on the front of the card

Cardholder Name (Please print) \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please complete and fax back to (818) 706-1738**