

AUTOMATIC TRANSFER AUTHORIZATION

ACCOUNT HOLDERS(S) to be debited: Name: _____ Address: _____ Phone: _____	FINANCIAL INSTITUTION: First Neighbor Bank, N.A. PO Box 500 - 1415 18 th Street Charleston, IL 61920
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In this authorization, the words, "we," "our," or "us" mean the Financial Institution and the words "you" or "your" mean the Account Holder(s).
Test following a box which is not checked does not apply to this agreement. You authorize us to make the following transfer of funds to?

First Neighbor Bank's Account holder(s) to be credited:

Name: Crisis Pregnancy Center DBA Choices Pregnancy & Health
Address: 260 W. Locust Ave., Charleston, IL 61920
Checking Account # _____

TO DEBIT ACCOUNT:

Bank Name: _____
Address: _____
City/St/Zip: _____ Phone: _____
Account Number: _____ Routing Number: _____
Type: Savings Checking Other

We will make transfers on the following basis:

Amount to be transferred \$ _____
Effective Date: _____ Termination Date: _____
Frequency: Weekly Monthly Other _____

If a transfer date is a non-processing day for us then the transfer will be made on the first processing day
 Before After the scheduled date.

By signing below, you acknowledge receipt of a copy of this Authorization.

Signature _____ Date: _____

Signature _____ Date: _____

Leave this section blank unless you want to STOP your automatic payment.
TERMINATION OF THIS AGREEMENT: Any one of you may cancel this agreement by giving us written notice.

Effective Date: _____

The undersigned cancels this Automatic Transfer Authorization.

Signed _____ Date: _____