HEALTHCARE ASSOCIATES CREDIT UNION
The healthy way to bank®

2441 Warrenville Road, Suite 400, Lisle, Illinois 60532
Call Center: 800.942.0158
hacu.org

Single Entry Direct Loan Payment ACH Origination Authorization Form

Complete and fax to: Accounting Department 630.276.5841

Member Name:_____ Member Number:_____

Loan Number:_____ Dollar amount of loan payment: $_____

Business hours phone number: (_____) _____ - _____

Name of Financial Institution: _____

Routing Number/ABA: _____ Account Number: _____

By signing this form, I acknowledge and authorize a $5 processing fee to be assessed for this expedited transaction. This fee will be added to the dollar amount I have indicated above. Fee does not apply to VISA® accounts.

Please attach copy of your voided check here.

CHECK

If a voided check is not available, please fill out all above information completely and accurately.
Deposit slips are not accepted.

All single entry items will post approximately 1 to 4 business days from the receipt of fax. I understand and agree that if the payment is returned for any reason, fees may be assessed. I will be responsible for alternate payment arrangement.

I hereby authorize HealthCare Associates Credit Union to initiate a Single-Entry ACH debit to my Checking ☐ or Savings ☐ (select one) indicated above at the financial institution named above and to debit the same such account. I certify that the information I provided is correct and that I am an authorized signer or designate of the account provided for ACH transactions and am entitled to provide this authorization. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Member Signature _____ Date _____

Received By		*for office use only*	Accounting Processed	
_____	_____		_____	_____
initials	date		initials	date