HEALTHCARE ASSOCIATES CREDIT UNION
The healthy way to bank®

1151 East Warrenville Road, Naperville, Illinois 60563
Contact Center: 630.276.5555
or 800.942.0158 toll-free
hacu.org

Recurring Entry Direct Loan Payment ACH Origination Authorization Form

(Not available for VISAs or revolving lines of credit. First Mortgages may only be set up using the once per month option.)

☐ **Add** ☐ **Change** ☐ **Delete**

ALL NOTIFICATIONS MUST BE GIVEN FIFTEEN (15) CALENDAR DAYS IN ADVANCE OF SCHEDULED PAYMENT.

Member Name ______________________________

Member Number ____________________ **Loan Number** ____________________

Starting on: ______________ (date), I wish to have ($__________________) deducted:

☐ Once per month on the following date: ____________.

☐ Every other ______________ (day of the week).

☐ Twice per month on the 16th and last day of the month.

I authorize HealthCare Associates Credit Union to initiate a recurring debit entry, and any necessary adjustments, via Electronic Funds Transfer through the Automated Clearing House (EFT-ACH) on my account at the depository financial institution listed below to pay my HealthCare Associates loan listed above. I understand and agree that I must allow HealthCare Associates fifteen (15) calendar days to process and initiate the EFT-ACH payment method for my loan, and that my loan payments are due by date(s) specified in my loan agreement. The EFT-ACH payment method does not, in any way, alter or change the obligations and/or requirements for payment of my loan.

Please attach a voided personal check for checking account debit OR a letter printed on letterhead from an officer of the financial institution verifying account information for savings account debit.

Name of Financial Institution ______________________________

Routing Number/ABA ____________________ **Account Number** ______________

☐ **Checking** ☐ **Savings**

HealthCare Associates Credit Union will attempt to withdraw each scheduled loan payment one time. If the debit is returned, I acknowledge that I must pay my loan payment and all accrued late fees by other means. I acknowledge that HealthCare Associates may assess a return fee as noted on the fee schedule. I understand that HealthCare Associates will not be responsible or liable for any penalties or charges assessed by any other financial institution as a result of returned transactions. HealthCare Associates will process the next scheduled payment; however, if for two successive months the payment is returned by the depository institution, this authorization will automatically terminate.

I understand and agree that if I fail to provide a written cancellation fifteen (15) calendar days in advance when the above loan has been paid in full, the recurring debit entry will continue and funds will be deposited to my share account at HealthCare Associates Credit Union.

I certify that the information I have 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 the ACH transactions to my account must comply with the provisions of U.S. law.

Member Signature ______________________________ **Date** ____________

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