POOLED TRUST SERVICES

For office use only:

Member ID #:
Effective Date:
Change Date:

Direct Debit Request Form

Donor/ Beneficiary:_____

Representative:_____

Bank Name: _____ City:_____ State:_____

Bank Routing Number:_____

Account Number:_____

Account Name:_____

Account Type: Checking ☐ Savings ☐

Please submit a void check along with your form.

Monthly Debit Amount: $_____

Monthly dates for direct debit are as follows: 3rd ,5th ,15th, 20th, 25th, & 30th.

Date of Monthly Debit :_____J_____ First Debit Month: _____

Please Note: This Debit will occur on or around the date above each month.

Note: If any direct debits are returned for insufficient funds, a $53 charge will apply.

Beneficiary/ Representative Signature: _____

FOR OFFICE USE ONLY:		
Account #:	Member ID #:	Processed By:

I authorize and request ***SCS Pooled Trust*** to initiate debit entries to my account at the depository financial institution indicated above. This authorization is to remain in full force and affect until SCS has written notification from me of its termination in such time and manner as to afford SCS and depository financial institution a reasonable opportunuty to act on it.

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