

<b>AUTHORIZATION FOR AUTOMATIC PAYMENTS FROM BANK ACCOUNT</b>			
My Name:		Name of Company Initiating Payments ("Company"): <b>Meridian Health Foundation</b>	
My Bank's Name & Branch:	My Bank's City, State & Zip:	My telephone number:  Best time to call:	
My Bank Account No:	My Bank's Routing Number (from checks):	Payment Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Other	Approximate Date of First Automatic Payment:
Amount of Each Payment:  <input type="checkbox"/> \$			
I hereby authorize Company and its bank, Bank of Marin ("Bank of Marin") to initiate withdrawals ("debits") from my <input type="checkbox"/> checking <input type="checkbox"/> savings account ("My Bank Account") identified above at My Bank identified above through the Automated Clearing House system. These debits are to be processed beginning on the date indicated above. If this date, or the same day of the month during which a subsequent debit is to be processed, is not a banking day on which the debit can be processed, the debit should be processed on the banking day before or after the scheduled date, at Company's option. I also authorize Company to initiate deposits ("credits") to My Bank Account to correct any errors that may have been made with debits from My Bank Account. I authorize My Bank to process these debits from and credits to my Bank Account.			
This authorization will remain effective until I give Company written notice to the contrary and Company has had a reasonable period of time to act on that notice. My revocation of Company's authority to initiate debits to My Bank Account will not affect Company's right to initiate credits to My Bank Account to correct or adjust a debit processed before my revocation of authority has become effective.			
I Warrant to Company, Bank of Marin and My Bank that:		Today's Date	
<input type="checkbox"/> Only my signature is needed on this authorization to make it effective for My Bank Account.	<input type="checkbox"/> Everyone whose signature is needed on this authorization to make it effective for My Bank account has signed it.	My Signature	
		Signature of Other Required Signer	

\*\*\*Please provide a voided check with this application.\*\*\*

Please mail forms and voided check to:

**Meridian Health Foundation**  
**c/o Bank of Marin**  
**1001 4th Street**  
**San Rafael, CA 94901-3105**

*Thank you for your contribution!*