THE TEARS FOUNDATION

Automatic Withdrawal Authorization

I/We authorize the TEARS Foundation to initiate debit entries my/our account at the DEPOSITORY (identified below), for the purpose of accomplishing the following preauthorized payments.
PURPOSE OF AUTHORIZATION: (check one)

- ☐ New Authorization
- ☐ Change to Existing Authorization
- ☐ Cancellation (I wish to cancel my automatic withdrawals from my account. I will allow a reasonable time for TEARS to act upon my request to terminate this agreement. (1 ach cycle)

Donor and Depository Information (please print or type)

Name	
Billing address	
City	
State	
ZIP Code	
Telephone (home)	
E-Mail	
Bank Name	
Address	
City, State, Zip	
Routing Number	
Account Number	
Bank Telephone	
Checking or Savings	

My/Our account will remain subject to its individual terms and conditions, which are not modified by this authorization. I/We acknowledge that the origination of these transactions must comply with the provisions of U.S. law.

I/We understand that this authorization will remain in full force and effect until the company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the TEARS Foundation and DEPOSITORY a reasonable opportunity to act on it.

I pledge $_____ to be withdrawn from my account between the 5th and 10th of each month.

NAME(S) (Print or type) _____

_____ _____

(Signature) (Date) (Signature) (Date)

Acknowledgement Information

Please use the following name(s) in all acknowledgements:

Please attach Voided Check: