

APPLICATION FOR AUTOMATIC PAYMENT PLAN
CITY OF ALVIN
UTILITY BILLING / COLLECTION DEPARTMENT
216 WEST SEALY ST
ALVIN, TX 77511

AUTHORIZATION AGREEMENT FOR PREARRANGED PAYMENTS

I HEREBY AUTHORIZE THE CITY OF ALVIN UTILITY BILLING/COLLECTIONS DEPARTMENT TO INITIATE WITHDRAWALS FROM MY DESIGNATED CHECKING ACCOUNT AT THE FINANCIAL INSTITUTION NAMED IN THIS APPLICATION FOR PAYMENT OF THE UTILITY BILL ATTRIBUTABLE TO MY DESIGNATED CITY OF ALVIN ACCOUNT NUMBER. THE WITHDRAWALS WILL NORMALLY OCCUR ON THE DUE DATE OF EACH MONTHLY BILL. I AUTHORIZE MY FINANCIAL INSTITUTION TO CHARGE SUCH WITHDRAWALS TO THE DESIGNATED ACCOUNT. I UNDERSTAND THE FIRST DRAFT ON MY DESIGNATED ACCOUNT FOR PAYMENT OF MY UTILITY BILL WILL OCCUR ON THE DATE THE BILL IDENTIFIED AS A AUTOMATIC PAYMENT BILL, AND THAT I AM RESPONSIBLE FOR DELIVERING PAYMENT TO THE CITY OF ALVIN ON OR BEFORE THE DUE DATE FOR ALL BILLS THAT I RECEIVE. I AGREE TO MAINTAIN IN MY DESIGNATED ACCOUNT A BALANCE AVAILABLE FOR IMMEDIATE WITHDRAWAL HEREUNDER IN AN AMOUNT SUFFICIENT TO PAY EACH MONTHLY BILL IN FULL AS IT BECOMES DUE. I ALSO AGREE TO NOTIFY THE CITY OF ALVIN PRIOR TO CLOSING OR CHANGING MY DESIGNATED ACCOUNT. I HEREBY REPRESENT AND WARRANT TO THE CITY OF ALVIN THAT I AM FULLY AUTHORIZED TO EXECUTE THIS AGREEMENT, PERMITTING THEM TO INITIATE WITHDRAWALS FROM MY DESIGNATED ACCOUNT, AND I AGREE TO PROTECT AND INDEMNIFY THE CITY OF ALVIN FROM ANY SUITS, CLAIMS OR CAUSES OF ACTION CONTESTING MY AUTHORITY TO DO SO OR CITY OF ALVIN'S RIGHT TO WITHDRAW FUNDS FROM MY DESIGNATED ACCOUNT IN ACCORDANCE HEREWITH. I UNDERSTAND THAT BOTH THE CITY OF ALVIN AND MY FINANCIAL INSTITUTION RESERVE THE RIGHT TO TERMINATE THIS PLAN AND / OR MY PARTICIPATION THEREIN. I ALSO UNDERSTAND THAT THE CITY OF ALVIN'S TERMS AND CONDITIONS FOR PROVIDING SERVICE SHALL REMAIN IN EFFECT AND APPLICABLE HERETO, AS FILED IN THE CITY ORDINANCE. I ALSO AGREE TO PROVIDE A VOIDED CHECK FOR VERIFICATION OF INSTITUTIONS NUMBERS AND MY ACCOUNT NUMBER FOR PROPER CREDIT OF PAYMENT. ONLY CHECKING ACCOUNTS WILL BE HONORED. IF YOU DESIRE NOT TO PAY THE EMERGENCY MEDICAL SERVICE DONATION YOU MUST SIGN AN ADDITIONAL FORM RELEASING THE CITY OF ALVIN FROM THE RESPONSIBILITY OF BILLING THE DONATION ON YOUR MONTHLY BILL.

CUSTOMER INFORMATION

CUSTOMER'S NAME AS IT APPEARS ON BILL

STREET ADDRESS AND/OR P.O. BOX

CITY, STATE, AND ZIP CODE

HOME PHONE

WORK/CELL PHONE

CITY OF ALVIN ACCOUNT NUMBER

DRIVER'S LICENSE NUMBER STATE

FEDERAL IDENTIFICATION NUMBER
(COMMERCIAL ACCOUNTS ONLY)

AUTHORIZED SIGNATURE(S) DATE

AUTHORIZED SIGNATURE(S) DATE

FINANCIAL INSTITUTION INFORMATION

NAME OF FINANCIAL INSTITUTION

BRANCH NAME PHONE NUMBER

ADDRESS AND / OR PO BOX

CITY, STATE, AND ZIP CODE

CUSTOMER'S NAME AS IT APPEARS ON FINANCIAL ACCOUNT

PLEASE **ATTACH A VOIDED CHECK** FOR CHECKING ACCOUNT FOR VERIFYING YOUR ACCOUNT NUMBER FOR PROPER PAYMENT AND CREDIT.

TRANSIT / ABA ROUTING NUMBER

CHECKING ACCOUNT NUMBER

AUTHORIZED SIGNATURE(S) DATE

AUTHORIZED SIGNATURE(S) DATE

PLEASE ATTACH A VOIDED CHECK FOR PROCESSING