



CAPITOL BANK

710 N. High Point Road, Madison, WI 53717 (608) 836-1616 Fax (608) 836-1615

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH TRANSACTIONS)

DEBIT ACCOUNT:

NAME ON ACCOUNT _____ DAYTIME PHONE _____
BANK NAME _____ CITY/STATE _____
ROUTING NO. _____ ACCT.NO. _____ CHK ___ SAV ___

CREDIT ACCOUNT:

NAME ON ACCOUNT aaaJ RUE'Eqtr _____ DAYTIME PHONE *82: #: 53/: 6: 8 _____
BANK NAME Ecr kqn'Dcpm _____ CITY/STATE O cf kuqp"Y K _____
ROUTING NO. _____ ACCT.NO. _____ CHK ___ SAV ___

TRANSACTION:

AMOUNT: \$ _____ WEEKLY _____ DAY OF WEEK _____
MONTHLY _____ DAY OF MONTH _____
BEGIN DATE _____ END DATE _____ (or N/A if not applicable)

OTHER INFORMATION:

AUTHORIZATION (must be signed by owner of **DEBIT** account):

I (we) authorize Capitol Bank to initiate debit entries to my (our) Checking or Savings account indicated above at the financial institution named above. This authorization is to remain in full force and effect for the number of transactions stated, or until Capitol Bank has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Capitol Bank a reasonable opportunity to act on it.

SIGNED _____ DATE _____

ADDRESS _____

CITY/STATE/ZIP _____

BANK EMPLOYEE INITIALS _____