WITHDRAWAL AUTHORIZATION FORM

I hereby authorize The ARVC Foundation, here in after called (The ARVC Foundation) to initiate withdrawals from my account at the financial institution named below, and if deemed necessary, in their sole discretion initiate adjustments for any transactions credited/debited in error.

This authorization is to be made in full force and effective until The ARVC Foundation has received written notification from me of its termination or withdrawal changes in such time and in such manner as to afford The ARVC Foundation and FINANCIAL INSTITUTION a reasonable opportunity to act on it. I acknowledge at the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Financial Institution Name	Financial Institution Address
Account Holder's Name	Check One ❑ Checking ❑ Savings
Account Number	Routing Number
Withdrawal Amount	Frequency
Day of Month to be Withdrawn	Account Holder's Signature:
	Date:

Note: In the event your preferred Withdrawal date falls on a weekend or holiday your withdrawal will occur the next business day after.

Thank you for supporting The ARVC Foundation.