CLEAR LAKE SANITARY DISTRICT

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I (we) authorize the Clear Lake Sanitary District to initiate debit entries to my (our) account indicated below and the depository to debit the same such account. This authority is to remain in full force and effect until written notification is provided by me (us) of its termination in such time and manner as to afford the Clear Lake Sanitary District the opportunity to cancel the transaction. *Please note that for each payment that is not received due to non-sufficient funds, a $20 fee will be applied to your next bill and CLSD may terminate your pre-authorized payments without notice and at its sole discretion.*

Signature _____ Date _____

Full Name (please print) _____

CLSD Account # _____

Property Address:

_____

_____

Mailing Address If Different Than Property Address:

_____

_____

Account Type _____ Checking _____ Savings

Bank Name _____

City _____ State _____ Zip _____

PLEASE ATTACH A VOIDED CHECK OR WITHDRAWAL SLIP FOR THE ACCOUNT YOU WANT THE PAYMENT DEDUCTED FROM.

FOR OFFICE USE ONLY

Bank #:_____

Transit/ABA #: _____ Bank Account #:_____

Date Entered: _____ Employee Initials: _____

Return Form To:
Clear Lake Sanitary District
P.O. Box 282, 5631 235th St.
Clear Lake, IA 50428
Phone: (641) 357-2019 Fax: (641) 357-7612
E-Mail: billing@clearlakesd.org Website: www.clearlakesd.org