

Scient Federal Credit Union P.O. Box 499 • 60 Colver Avenue Groton, CT 06340-0499 Tel: 877 860 MYCU www.scientfcu.org

EXTERNAL WITHDRAWAL AUTHORIZATION

Print form, complete, and fax to 860-441-0989 or mail to:

Scient FCU **Operations Department** P.O. Box 499 Groton, CT 06340

I/We hereby authorize Scient FCU ("Company") to initiate debit entries to my/our account indicated below and the financial institution ("Financial Institution") named below to debit the same to such account.

we acknowledge that ACH transactions I/we authorize must		
Financial Institution Name	Scheduled Date of Credit **DEBIT POSTS PRIOR DAY**	
Routing Number	Recurring Debit If Yes, Frequency Solution Yes No	
Account Number	Regular Payment Fixed Amount □ Yes OR \$	
Type of Account ☐ Checking ☐ Savings	Credit to Account	
his authority is to remain in full force and effect until I/we notify the Company of its termination with a Right to Revoke uthorization received by the Company at least 3 business days prior to the next scheduled transaction. he Company has established a limit of \$3,500 per transaction. The member is responsible for providing the Company ith accurate information for the Financial Institution. The member agrees the Company is not responsible for posting rrors associated with the provided information. The Company reserves the right to revoke and/or terminate this		

Т W authorization should the member have two consecutive failed ACH entries for any ACH return reason including but not limited to invalid information or Non-sufficient Funds.

The Company will obtain written authorizations for consumer entries in accordance with applicable laws and ACH Rules and shall retain record of said authorizations for two (2) years after termination or revocation of such authorization.

PLEASE ATTACH A COPY OF A VOIDED CHECK OR DEPOSIT TICKET TO THIS FORM.

Print name	Member Number
Signature	Date