PETERS TOWNSHIP SANITARY AUTHORITY

111 BELL DRIVE
McMURRAY, PA 15317-3415
PHONE: 724-941-6709
FAX: 724-941-2283
Web Site: ptsaonline.org

AUTHORIZE FOR AUTOMATIC PAYMENT WITHDRAWAL (ACH) FOR QUARTERLY PAYMENTS

Thank you for requesting automatic payment withdrawal for your Peters Township Sanitary Authority sewer account. With this process, a monthly payment will be withdrawn from your bank checking account or savings account, automatically on the due date specified on the bill. Please allow thirty (30 days) following receipt of this authorization for the auto pay processing to begin. Continue to pay your bill as usual until there is a notice on the bill indicating that an automatic payment transaction will be created to pay this bill.

ANY CHANGES TO OR DISCONTINUATION OF THIS WITHDRAWAL SCHEDULE MUST BE REQUESTED AT LEAST TEN (10) WORKING DAYS PRIOR TO THE DUE DATE SPECIFIED ON YOUR BILL AND MUST BE MADE IN WRITING.

If there are insufficient fund in the account to complete the withdrawal, there will be a $50 fee assessed to cover our bank account.

* A separate authorization agreement must be completed for each account that automatic payment withdrawal is requested.

Customer Information

Customer Name _____ Account Number _____

Billing Address _____ Service Address _____
(If different than billing address)

City, State, Zip Code _____ City, State, Zip Code _____

Contact Phone No. _____ Email _____

Bank Information

Financial Institute _____ Name (s) on Bank Account_____

Account No._____ Route No. _____

Checking _____ or Savings _____

PLEASE ATTACH A VOIDED CHECK OR DEPOSIT SLIP WITH THIS APPLICATION AND MAIL TO PTSA 111 BELL DRIVE MCMURRAY, PA 15317

** AUTHORIZATION AGREEMENT **

I (we) hereby authorize the financial institute designated in this application to charge the account specified above payment of my service. I (we) understand that a fee will be charged to my account for each automatic payment request return. If two authorization request are returned, I (we) will be excluded from further participation in the plan. In addition, I (we) understand that reserves the right to terminate this payment plan and/or my (our) participation therein.

Signature _____ Date _____

Print Name _____

OFFICE USE ONLY

Date Received _____ Date Entered _____ Letter Sent _____

"This Authority is an Equal Opportunity Provider"