DELTA MANAGEMENT
ASSOCIATES, INC.

Office Hours: Mon.-Thurs. 8:00 a.m.-9:00 p.m.
Fri. 8:00 a.m.-5:00 p.m., Sat. 8:00 a.m.-12:00 p.m.
fins@deltamanagementassociates.com

RECURRING ACCOUNT DEBIT CONSENT AND AUTHORIZATION FORM

Name: ____ Delta Account Number: ___________________

Social Security Number (SSN)/Last Four Digits of SSN: ________________________

Primary Telephone Number: _______________________________

Mobile Phone Number: ____________________________

E-mail Address: ____

Date of Verbal Authorization (if applicable): ____/____/____

Account Number to be Debited: ____

Expiration Date (if applicable): ____/____/____

Checking Routing Number (if applicable): ____

Amount of Debit: $__________________

Number of Payments: _________ Payment Start Date: ____/____/____

Payment Frequency (select one):

Monthly Payments: Date of Month: ________________ Weekly Payments: Day of Week: ______________

Biweekly Payments: Start Date: ____________________ Day of Biweekly Payment: ___________________

I hereby authorize Delta Management Associates, Inc. to make recurring debits from my bank account, debit card or credit card using the above-listed information. I understand this authorization will remain in effect until I cancel it in writing, and I agree to notify the payee in writing of any changes in my account information or termination of the authorization prior to the date payment is processed.

Retain a copy of the signed form for your records.

Signature: ____ Date: _______________

This is a communication from a debt collector. This is an attempt to collect a debt. Any information obtained will be used for that purpose.