



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.
loaninfo@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.