



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.
review@delta123.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.