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@delta-mgt.com

# RECURRING ACCOUNT DEBIT CONSENT AND AUTHORIZATION FORM

Name: _____ Delta Account Number: _____

Last Four Digits of Social Security Number (SSN): XXX-XX-_____

Primary Telephone Number: _____

Mobile Phone Number: _____

E-mail Address: _____

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

Account Number to be Debited: XXXX XXXX XXXX_____

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 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.