AUTOMATIC TRANSFER AUTHORIZATION

ACCOUNT HOLDERS(S) to be debited:	FINANCIAL INSTITUTION:
Name: _____ Address: _____ Phone: _____	First Neighbor Bank, N.A. PO Box 500 - 1415 18th Street Charleston, IL 61920

In this authorization, the words, "we," "our," or "us" mean the Financial Institution and the words "you" or "your" mean the Account Holder(s). Test following a box which is not checked does not apply to this agreement. You authorize us to make the following transfer of funds to?

First Neighbor Bank's Account holder(s) to be credited:
Name: Crisis Pregnancy Center DBA Choices Pregnancy & Health
Address: 260 W. Locust Ave., Charleston, IL 61920
Checking Account # _____

TO DEBIT ACCOUNT:

Bank Name: _____

Address: _____

City/St/Zip: _____ Phone: _____

Account Number: _____ Routing Number: _____

Type: ☐ Savings ☐ Checking ☐ Other

We will make transfers on the following basis:

Amount to be transferred $_____

Effective Date: _____ Termination Date: _____

Frequency: ☐ Weekly ☐ Monthly ☐ Other _____

If a transfer date is a non-processing day for us then the transfer will be made on the first processing day
☐ Before ☐ After the scheduled date.

By signing below, you acknowledge receipt of a copy of this Authorization.

Signature_____ Date: _____

Signature_____ Date: _____

Leave this section blank unless you want to STOP your automatic payment.

TERMINATION OF THIS AGREEMENT: Any one of you may cancel this agreement by giving us written notice.

Effective Date: _____

The undersigned cancels this Automatic Transfer Authorization.

Signed_____ Date: _____