STAGEBARN SANITARY DISTRICT
AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL

I hereby authorize Stagebarn Sanitary District to initiate debit and, if necessary, credit entries to my account indicated below for my Stagebarn Sanitary District bill. I understand that the amount deducted will be my balance due indicated on the current bill. The withdrawal will take place on the 1st of each month or the next business day if the 1st falls on a holiday or weekend. I acknowledge that this authorization is to remain in effect until Stagebarn Sanitary District has received written or verbal notification of its termination.

THERE WILL BE A SERVICE CHARGE IF FUNDS ARE NOT AVAILABLE

PLEASE PRINT CLEARLY

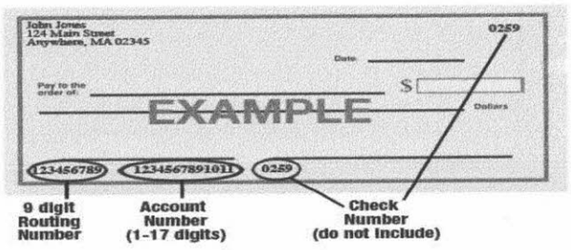
Name: _____

Stagebarn Account #: _____

Address: _____

Phone Number: _____

Attach a voided check to form



Name of Bank: _____

9-Digit Routing #: _____

Account #: _____

Type of Account: ☐ Checking ☐ Savings (check one)

Attach a voided check to form

Date _____

Signature _____

Please mail completed form to:

Stagebarn Sanitary District
PO Box 703
Black Hawk, SD, 57718