

Columbus, OH Branch
Tracir Financial Services, Inc.
2040 Brice Rd. Ste 200
Reynoldsburg, OH 43068
Phone 888-737-2622
Fax 877-288-3391



Jackson, MS Branch
Tracir Financial Services 1, Inc.
1080 River Oaks Dr. Ste B-100
Flowood, MS 39232
Phone 866-443-0877
Fax 866-443-0760

Payment Plan Authorization Form (ACH Debits)

We are pleased to offer you the convenience of an Automatic Recurring Payment Plan.
Now you can have your payment automatically deducted from your checking or savings account.

- It saves time – fewer checks to write and mail.
- Helps pay your bills in a convenient and timely manner – even if you're out of town.
- Helps maintain good credit – your payment is always on time.
- Saves postage

Full Name: _____

Tracir Account#: _____

Start/Pay Date: Month: _____ Day: _____ Year: _____

(Start date must be at least 15 business days from date form is sent AND MUST BE SET UP FOR A WEEK DAY)

Payment Amount: \$ _____

Customer's Bank Information

Bank: _____ Account Type (Select One) Checking _____ Savings _____

Address: _____

Routing Number: _____

Account Number: _____ (Please attach one voided check to this form)

Payment Authorization

I authorize my bank to debit my account as identified above to the terms stated here. This authorization shall remain in effect until the Service Provider and bank receive written notification from me on intent to terminate at such time and in such manner as to afford the Service Provider and bank reasonable opportunity to act (minimum 30 days).

I understand that if the total amount owed to the service provider is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed the Service Provider is paid off, or unless the plan is terminated earlier by me as above. I understand any added amounts can be applied for with a new authorization form.

All other changes such as payment amount, frequency, bank account number change, will require a new Payment Authorization Form to be filled out and submitted to Central Ohio Credit Corporation 15 days prior to any changes being implemented. I understand that this payment plan may be cancelled by the service provider or Tracir due to NSF (Non-Sufficient Funds). I will be liable to pay an NSF fee of \$15.00 which may be automatically debited for each NSF situation.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the Service Provider, the bank, and Tracir harmless from damage, loss or claim resulting from all authorized actions hereunder.

Customer's Signature: _____ Date: _____

Second authorized signature of _____

Bank account if required: _____ Date: _____

Please fill out this form, attach a voided check and mail/fax or drop off at the above address.

Note: Customer should print out and keep a copy of this completed form for their records.