AUTOMATIC PAYMENT REQUEST FORM

Print and complete this form to request the transfer of an automatic payment. Each company or organization which you have arranged automatic payment must be provided with this form. Please allow sufficient time for your first automatic payment to be activated.

Date: _____

Company name:_____

Account number: _____

Your information:

_____
Name

_____
Address

_____
City, State, ZIP

_____
Home phone Work phone

I am requesting that my payment be automatically deducted from my account with:

Paper City Savings Association
PO Box 339
Wisconsin Rapids WI 54495-0339

Account number _____

Routing number _____275971498_____

Date or Frequency of Payment_____ Amount _____

Please discontinue payments automatically deducted from the account I have closed at:

_____
Previous Financial Institution Name

_____
Account Number

If you have any questions regarding this request, please contact me by mail or call me at the phone number listed above. If this form is not sufficient for automatic payments, please forward the authorized company form for my signature.

_____ _____
Signature Date