



DEBIT AUTHORIZATION

I (we) hereby authorize Superior Health Foundation, hereinafter called Company, to initiate debit entries to my (our) account indicated below and the financial institution named below, hereinafter called Financial Institution, to credit the same to such account.

I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Financial Institution			
_____		_____	_____
Address		City/State	Zip
_____	_____	___ Checking	___ Savings
Routing Number	Account Number		
\$ _____	_____		
Dollar amount of gift	Frequency of gift (one-time, biweekly, monthly, etc.)		

This authority is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and manner as to afford Company and Financial Institution a reasonable opportunity to act on it.

_____	_____
Signature	Date

Printed Name	
_____	_____
Signature	Date

Printed Name	

***PLEASE ATTACH COPY OF A VOIDED CHECK TO THIS FORM**

Please send this form to: Superior Health Foundation, Attn: Laura Jarvi,
121 N. Front Street, Marquette, MI 49855.
Email to ljarvi@superiorhealthfoundation.org, or fax to (906) 225-6916.