Recurring Payment Authorization

Please Pay (vendor name) _____

Payment Mailing Address _____

_____

Start Date of Payments _____ End Date (if applicable) _____

Amount to be paid _____ Account # _____

Payment is due on the _____ of each month.

Select One: ☐ Authorize **Monthly** Payments (up to 12 payments per year) ☐ Authorize **Quarterly** Payments (up to 4 payments per year)

Select One: ☐ Copy of invoice or bill attached ☐ Invoice or bill will be mailed to Arcare

By signing below, you authorize Arcare, Inc. to set up the monthly/quarterly payment referenced above to be debited from your account until the indicated end date or until we are notified by you to cancel the request. Please allow at least 30 days notice for any cancellations. You must notify us in writing by completing a new form of any changes made to this payment.

Incomplete forms will not be processed and will be returned to the beneficiary.

(Beneficiary is the person for whose benefit the trust has been established.)

_____ _____
Name of Beneficiary (please print) Phone Number

_____ _____
Signature of Beneficiary/POA/Guardian/Designee Date

Mail, fax or email this completed form to:
PO Box 12890 | Overland Park, KS 66282
Fax: 913.648.0057 Email: info@arcare.org

arcare
Planning today for your loved one's tomorrow

For internal use only.

Approved by _____ Date _____ *Rev. 2/18*