Recurring Payment Authorization

Please Pay (vendor name) _____

Payment Mailing Address _____

_____

Billing Account # _____ Payment Due Date _____

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

Select One:

Authorize **Monthly** Payments
(up to 12 payments per year)

Estimated Payment $ _____

(Insurance Payments Only)
Authorize **Bi-Annual** Payments
(2 payments per year)

Estimated Payment $_____

Authorize **Quarterly** Payments
(up to 4 payments per year)

Estimated Payment $ _____

(Insurance Payments Only)
Authorize **Annual** Payments
(1 payments per year)

Estimated Payment $_____

The recurring payment option requires you to have the bill/invoice mailed direct to Arcare. Please contact the vendor and change your mailing address on file to:

(Name of Beneficiary)
c/o Arcare Trust Department
PO Box 12890
Overland Park, KS 66282

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. 2/23*