

Condo Management Associates LLC

Name of Condo Association: _____

Collections Program

CONDO MANAGEMENT ASSOCIATES, LLC
P.O. BOX 44660
MADISON, WI 53744-4660

AUTHORIZATION – Please fill out and return to:

I authorize you and the financial institution listed below to initiate electronic debit entries, and if necessary, credit entries and adjustments for any debit entries in error to my:

Checking Account

Savings Account

This authority will remain in effect until I have cancelled it in writing.

Amount of Monthly Withdrawal

DATE YOU WANT WITHDRAWAL TO START

FINANCIAL INSTITUTION

NAME (PLEASE PRINT)

BRANCH

ACCOUNT NUMBER AT FINANCIAL INSTITUTION

CITY

STATE

SIGNATURE

I authorize you and the financial institution listed above to increase the amount of my monthly withdrawal with an approved Association Budget.

E-Mail Address To Send Confirmation Of Set Up _____

STAPLE VOIDED CHECK HERE.....

****There is a \$25.00 fee for any Automatic Withdrawals that are rejected by your bank for any reason.**