HARBOR SANITARY DISTRICT

Automated Bank Payment Authorization

Please complete the information below.

Name (As it appears on your bill) _____

Harbor Sanitary District Account # _____

Bank Name _____

Bank City & State _____

Bank Routing # (9 Digits) _____

Bank Account # _____

Do you want to continue receiving monthly statements for your records? _____

I hereby authorize Harbor Sanitary District to electronically debit the bank account indicated above on a monthly basis, for the balance due on my account. This authorization will remain in effect until I have provided seven days prior notification of cancellation to Harbor Sanitary District. I understand that my bank account will be debited on the **10th day of each month**, and I am solely responsible for maintaining sufficient funds in my account to cover full payment. I understand if the funds in my bank account are not adequate to cover the amount of my bill, a fee for non-Sufficient funds will be imposed.

_____ _____

Authorized Signature Date

Attach a voided check or a photocopy of a check and return the completed form to:

Harbor Sanitary District
P.O. Box 2457
Brookings, OR 97415

or email to: harborsan@frontier.com