



Automatic Payments/Electronic Funds Transfer (EFT) Authorization Form

INSTRUCTIONS

Step 1: Complete the Customer Information and Preferred Payment Option Information Below.

Step 2: Sign the Authorization Form.

Step 3: Return the form to Carmichael Water District by:

Mail to: 7837 Fair Oaks Blvd, Carmichael, CA 95608

Email to: Billing@carmichaelwd.org

Fax to: 916-483-5509

Step 4: Continue paying your water bill until you receive a confirmation letter or until indicated on your Billing Statement.

Set Up New Auto-Pay

Update Auto-Pay Information

CUSTOMER INFORMATION

Customer Name: _____ CWD Account Number: _____
(Please Print)

Service Address: _____ City: _____

Email address: _____ Preferred Contact Number: _____

PREFERRED PAYMENT OPTION

PREFERRED CARD [Check One] Visa MasterCard Discover | Debit Credit

Name as it Appears on Card: _____ Card Number: _____
(Please Print)

Expiration Date: Month _____ Year _____ Card Security Number: _____ Card Billing Zip Code: _____

CHECKING ACCOUNT (A VOIDED CHECK IS REQUIRED FOR THIS OPTION)

SAVINGS ACCOUNT

Bank Routing Number: _____ Checking/Savings Account Number _____
(Bank/Institution Identification Code - Typically first 9 numbers displayed on Check) (Typically second set of 9 to 10 digit numbers displayed on Check)

AUTHORIZATION AGREEMENT

I hereby authorize Carmichael Water District (CWD) to deduct funds from preferred payment option (PPO) indicated above to pay my water bill on the due date shown on my bill. I understand that if desired, it is my responsibility to stop automatic payments by notifying CWD in writing 30 days prior to my next due date. By authorizing CWD to deduct funds from my PPO above, I acknowledge that payment of my water bill still remains my responsibility. I agree and understand that CWD cannot be responsible for any failures of my financial institution to transfer funds, failure of mine to maintain sufficient funds in the paying account, or for any failures of transfer due to circumstances arising from problems in the electronic transfer system. I further understand that if two payments are returned, for any reason, within a twelve month period my participation in the EFT program will be automatically cancelled.

By signing below I am authorizing CWD to deduct funds from my card/bank account indicated above, however, I agree and understand that CWD has no control over the EFT process and, therefore, cannot guarantee the security of my financial information. **I understand that if my Payment or CWD Account ownership information changes for any reason, it is my responsibility to inform CWD within 30 days prior to my next due date.**

Customer/Card Holder's Signature: _____ Date: _____

VISIT www.carmichaelwd.org for answers to common questions and additional information.

For Billing Department Use Only:

Received Date: _____ Processed Date: _____ Processed By: _____