Automatic Payment Authority

ASB

Statement account only

Account number you'd like the recurring payment to be paid from

(Not to operate as an assignment or an agreement)

Branch where my/our account is held

Please start this Automatic Payment by debiting my/our account. Details are

◯ New Payment

or

◯ Change existing payment number ___ to the same account holder

Amount

$

Start/Change date

D D M M Y Y Y Y

Frequency

Monthly, quarterly or yearly

Pay to (name)

Muscular Dystrophy Association

Pay to (account no.)

1 2 3 0 7 7 0 4 7 4 7 1 8 0 2

Until

◯ Further notice

or

◯ a final payment amount of $

On

D D M M Y Y Y Y

1. Information to appear on their Statement

Particulars

Donor number

Code

Last name

Reference

R E G U L A R

2. Information to appear on my Statement

Particulars

M D A N Z

Code

R E G U L A R

Reference

D O N A T I O N

3. Conditions

I/We understand and accept that the Bank accepts this authority only upon the conditions on the reverse of this authority.

Name of Personal Account ◯ Mr ◯ Mrs ◯ Miss ◯ Ms

Name

or

Name of Business Account

1. Customer's Signature

Date

D D M M Y Y Y Y

Contact Phone Number

2. Customer's Signature

Date

D D M M Y Y Y Y

Contact Phone Number

1. The Bank will use reasonable care and skill to give effect to the directions given in this authority.
2. Where the directions given in this authority have been given by me/us for the purpose of a business, the Bank accepts those directions without any responsibility or liability for any refusal or omission to make all or any of the payments or for late payments or for any omission to follow such directions.
3. The bank accepts no responsibility or liability for accuracy of the information contained in the payment information fields on this authority.
4. I/We undertake to advise the Bank immediately of any information about payments shown on bank statements which is incorrect.
5. This authority is subject to any arrangements now or hereafter subsisting between myself/ourselves and the Bank in relation to my/our account.
6. The Bank may in its absolute discretion conclusively determine the order or priority of payment by it of any monies pursuant to this or any other authority which I/we may now or hereafter give to the Bank or draw on my/our account.
7. The Bank may in its absolute discretion refuse to make any one or more payments pursuant to this authority where there are insufficient funds available in my/our account.
8. This authority may be terminated or reduced by the Bank or the payee without notice to me/us in respect of the payments detailed over.
9. This authority will remain in force and effect in respect of all payments made in good faith notwithstanding my/our death or bankruptcy or any other revocation of this authority until notice of my/our death or bankruptcy or other revocation is received by the Bank.
10. All current Bank and Government charges for this service in force from time to time are to be debited to my/our account.

FOR BANK USE ONLY

Form Accepted by

Details Alt/Loaded by

Form Verified by

Checked to DBR of

Date stamp

Thank you

Thank you for your application to join our regular giving programme – Friends of MDA.

After completing the Muscular Dystrophy Association's bank Automatic Payment form overleaf, we ask that you post it to us using the reply-paid envelope if you received this by mail, or if you downloaded it from our website, please post it to:

P.O. Box 12063, Penrose, Auckland 1642

Alternatively, to save on postal costs, you can take it into the branch of your bank for processing.

If you have any questions, we welcome you to contact us at **info@mda.org.nz** or call on **0800 800 337**.

Muscular Dystrophy New Zealand

Charity Registration Number CC31123