

CheckEase Direct Giving Enrollment Form



Christian Healthcare Ministries

Galatians 6:2, Acts 2 & 4

Name: _____ CHM #: _____

I (we) hereby authorize **Christian Healthcare Ministries**, hereinafter called CHM, and the depository financial institution named below, hereinafter called DEPOSITORY, to initiate electronic debit entries, and if necessary, credit entries to my account listed below. I (we) acknowledge that the origination of debit transactions to my (our) account must comply with the provisions of U.S. law.

(Financial institution name)

(Branch)

(Address)

(City, state, zip)

(Routing number)

(Account number)

Checking account

or

Savings account

This authority is to remain in full force and effect until CHM has received written notification from me of its termination in such time and manner as to afford CHM and DEPOSITORY a reasonable opportunity to act on it.

(Print participant name)

(Signature)

(Print CHM number)

(Date)

Please specify:

Monthly gift amount: \$ _____

Month/year CheckEase debit to begin: _____

Date of monthly CheckEase debit to occur: 1st 3rd 5th 10th 15th 20th 25th

(Note that if this date falls on a weekend or holiday, the amount will be withdrawn on the next business day).

PLEASE ATTACH COPY OF VOIDED CHECK (if choosing checking account) OR DEPOSIT SLIP (if choosing savings account).

**Return form to: Christian Healthcare Ministries 127 Hazelwood Ave.
Attn: CheckEase Direct Giving Barberton, OH 44203**

Questions?
330-798-6555 or 800-791-6225, ext. 6555
330-798-5234 fax • swhite@chministries.org
www.chministries.org