PAYMENT AUTHORIZATION FORM

Date: _____

Name: _____

Address:_____

Mailing Address:_____

_____

Customer's City Account # _____

Withdraw from: _____(Bank Name)

Customer's Bank Account # _____

Type of Account: Checking _____(or) Savings _____

Bank's Routing and Transit number _____

I, _____, hereby request the city to send my bill payment through the

above referenced bank and account number monthly starting _____.

_____

Customer's signature

********** *PLEASE ATTACH A VOIDED CHECK or IMPRINTED DEPOSIT SLIP* **********

DISHONORED CHECK POLICY

The City of St John hereby adopts the following policy for all dishonored checks:

1. The maker of the check shall be responsible to pay the full amount of the dishonored check.
2. The City is entitled to charge the maker of the dishonored check all bank charges for collection on the dishonored check plus an additional $50.00 fee allowed by K.S.A. 21-3707.
3. The City will pursue all remedies available under K.S.A. 60-2610 et seq and K.SA. 21-3707.
4. No check will be accepted from the maker for one (1) year following receipt of the dishonored check.

Approved by the council this 16th day of December, 2008.

City Office Use Only

Mail Code: **5** SJNB
6 ASB
7 OTHER

Input into Computer _____
Prenote Run _____
Live Run _____
Spreadsheet _____
Copy to Bank _____