

## Auto-Pay Cancellation Request

Request for auto-pay deductions must be received **30 days** prior to the next billing cycle. Please fill out the form below and give it to a staff member.

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Cancel auto pay starting \_\_\_\_\_, 20\_\_\_\_

Reason: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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For internal use:

Date Received: \_\_\_\_\_

Staff Name: \_\_\_\_\_