



AUTHORIZATION TO KEEP FINANCIAL INFORMATION ON FILE

Date: _____

Name: _____

Address: _____

Account(s) _____

I authorize Gragil Associates, Inc. to save my financial information for the sole purpose of paying the above mentioned account(s). This is not an authorization to automatically deduct payments. I understand that it is my responsibility to call the office in order to process my payment.

<input type="checkbox"/> Checking
Name on Acct _____
Address on Check _____
Bank Routing # _____
Last 4 Digits of Acct # _____

<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
<input type="checkbox"/> Amex <input type="checkbox"/> Discover
Cardholder Name _____
Last 4 Digits of Acct # _____
Exp. Date _____
CCV (3 digit number on back of card) _____

****Please contact our office at 1-800-336-0299 with your complete checking/credit card account number.**

Signature _____ Phone# _____

Form can be emailed, mailed or FAXED to:

Gragil Associates, Inc.
P.O. Box 1010
Pembroke, MA 02359
FAX: 781-826-6367
collections@gragil.com