CHIROPRACTIC FEDERAL CREDIT UNION

Automatic Payment Cancel Form

Give this to Company/Payee

Please cancel this automatic payment per my instructions:

Company to receive payment_____ Account Number_____

Company Address_____

City_____ State_____ Zip_____

Previous Financial Institution_____ Account Number_____

Payment Amount $_____

- ❒ Monthly
- ❒ Bi-Weekly
- ❒ Weekly

I authorize my automatic payment to be canceled effective _____/_____/_____

Authorized Signature(s)_____ Date_____

Authorized Signature(s)_____ Date_____

CHIROPRACTIC Federal Credit Union

23617 Liberty • Farmington, MI 48335
248-478-4020 • 800-422-6424 • Fax: 248-478-7632
www.chirofcu.org