ENROLL ONLINE TODAY!

Create an account using the instructions on your current statement to enroll in autopay online.
Feel free to contact our office for a copy of your current statement.

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS

Dear Homeowner,

Use this form to authorize the association to debit your checking account during the first 10 days, at payee staff's discretion, each month for your monthly assessment amount plus any other charges billed. This is a free service offered by the management company.

You will continue to receive a monthly statement prior to the debit so that you can review the charges to your account in advance of the debit. Be sure to review your monthly statement each month.

Your start date will be the first day of the month following your submission of the form as long as we receive it before the first of the month.

****

ASSOCIATION NAME: _____

ACCOUNT NUMBER OR PROPERTY ADDRESS: _____

EMAIL ADDRESS: _____

You will be automatically enrolled in Paperless Statements using the email address above. Check here to opt out: ☐

Effective the first day of each month, I (we) hereby authorize THE ASSOCIATION to initiate debit entries to my (our) Checking account indicated below for my monthly Association Fees at the depository (bank) named below, hereinafter called DEPOSITORY. I (we) authorize the Association to initiate the original debit entry in an amount equal to the unpaid balance on my (our) assessment account and to debit for all charges to my (our) assessment account unless I (we), in writing, dispute a charge prior to the debit. I (we) understand that the debit to my (our) checking account will occur during the first ten (10) days of the month, at payee staff's discretion. Any attempts to alter this agreement as it is written by crossing out type-written words or writing in special requests or by any other means that attempt to alter the agreement as it is written will void this form.

DEPOSITORY (BANK) NAME _____

TRANSIT / ABA (ROUTING) # _____ ACCOUNT # _____

☐ Checking Account ☐ Savings Account

NAME (S) _____

(Please Print)

PLEASE ENCLOSE A VOIDED CHECK REFLECTING THE ABOVE ACCOUNT INFORMATION

DATE _____ SIGNED _____

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

ATTACH VOIDED CHECK HERE
*****Please DO NOT use staples*****

Return form to our office by Email (Preferred) or Mail

Accounting@partnerscm.com

1107 Fair Oaks Ave., #107 South Pasadena, CA 91030