AUTHORIZATION AGREEMENT

Please complete the following form only if you are requesting to pay your monthly bill by *one of the following methods*:

Name: ______________________________

Address: ______________________________

City: ______________State: __________ Zip: __________

Daytime Phone #: ______________ Evening Phone #: ______________

Billing Telephone #: ______________________________

Pre-Authorized Credit / Debit Card Payment (Recurring Credit)

I (we) hereby authorize SCTelcom to initiate credit / debit entries for payment of monthly services.

_______Visa _______Mastercard Bank: ______________________

Card #: ______________________ 3 digit verification # on back of card: __________

Expiration Date: ______________

______________________ ______________________
Signature Date

Pre-Authorized Bank Debit Payments (ACH)

I (we) hereby authorize SCTelcom to initiate debit entries for payment of monthly services.

Bank: ______________________ Routing #: ______________________

Bank Account #: ______________________________

City: ______________State: __________ Zip: __________

______________________ ______________________
Signature Date

This authority is to remain in full force and effect until SCTelcom and Bank has received written notification from me (or either of us) of it's termination in such time and in such manner as to afford SCTelcom and Bank reasonable opportunity to act on it.

Please return form to:
Billing Department, PO Drawer B, Medicine Lodge, KS 67104