VITALink Automatic Bill Payment Authorization

I (we) authorize VITALink, LLC. to instruct my (our) bank/savings institution to make my (our) payments from the account listed below. I (we) understand that I (we) control my (our) payments, and if at any time I (we) decide to discontinue this payment service, I (we) will notify VITALink, LLC. in writing to discontinue automatic bill payment. I (we) understand that any automatic bill payment transaction from my (our) account must comply with the provisions of the U.S. law.

Customer name: (as it appears on your bill)	
Service address:	
City, State Zip	
Financial Institution:	
Account Holder Name: (as it appears on your check)	
Type of Account	◯ CHECKING ◯ SAVINGS
ABA/Routing Number:	
Account Number:	

Account Holder Signature:	
Account Holder Signature:	
Date:	

Email
billing@qcol.net

FAX:
724-329-1302

Mail:
VITALink Billing
PO Box 100
Markleysburg PA 15459