



Please Read Entire Document!

### Electronic Funds Transfer Agreement

I, \_\_\_\_\_ (please print), hereby authorize my financial institution to make my monthly dues payment to **Health Unlimited Family Fitness and Aquatic Center** on my behalf. This transaction will take place **on the 2<sup>nd</sup> of each month (or the next business day, if the 2<sup>nd</sup> falls on a weekend or holiday)**.

\_\_\_\_ Checking account (attach *voided check* to EFT slip)  
\_\_\_\_ Savings                      Bank Name \_\_\_\_\_  
\_\_\_\_ Mastercard/Visa      \_\_\_\_ Discover  
\_\_\_\_ Debit card (attach *voided check* to EFT slip)

We recommend using your checking or savings acct for your monthly EFT draft. Credit and debit cards get lost, are stolen, expire or are changed and result in 80% of our EFT returns.

Credit Card Account # (last 4 digits only) \_\_\_\_\_ Exp. Date \_\_\_\_\_  
**(full account information to be entered on separate form – EFT slip)**

I understand that if I choose to pay my dues via cash/check/credit card **by the 20<sup>th</sup> of the preceding month**, my account/credit card will not be charged electronically. However, should I fail to meet this deadline, my account/credit card will be automatically assessed the appropriate dues amount **including any previously owed dues not already collected**.

Should the EFT payment attempt **fail for any reason**, I understand that I will be responsible for the dues owed **plus a \$15 return charge** per item. **If the EFT attempt should fail, Health Unlimited will reattempt on the 5<sup>th</sup> of the same month. If corrected account information is required, a reattempt will be made upon receipt of this new information.**

I understand that, should my account begin to run an overdue or outstanding balance, each subsequent EFT draft will attempt to collect all appropriate monies owed up to that point. Once the outstanding balance has been satisfied, the monthly EFT draft will return to collecting only the monthly dues indicated by the membership agreement pertaining to this account.

I further understand that, should anything change concerning the status of my account/credit card (e.g. canceled, stolen, lost, expired, etc.), it is my responsibility to notify Health Unlimited in writing and provide updated EFT information to avoid additional return charges. I understand that if this change takes place after the 20<sup>th</sup> of the month, this new EFT information may not be effective for the next automatic draft and that my original EFT account/credit card may be charged. **This agreement remains in affect through any such changes in account information or method of EFT chosen.**

### CANCELLATION POLICY

Should I decide to cancel my membership after my initial year has been completed, I understand I must do so in writing **no later than the 20<sup>th</sup> of the month preceding my next automatic dues payment**. For example, if I wish to cancel prior to March 2<sup>nd</sup>'s EFT draft, I must have written notice to Health Unlimited no later than February 20<sup>th</sup>. Cancellation may be mailed to 103 Century Dr., Mt. Airy, MD 21771 or an e-mail may be sent to [help@myhealthunlimited.com](mailto:help@myhealthunlimited.com). **If canceling via e-mail, a verification response from Health Unlimited is necessary before the cancellation is complete.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Home Phone \_\_\_\_\_

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\_\_\_\_\_ Mastercard/Visa          \_\_\_\_\_ Discover          \_\_\_\_\_ Debit card (attach voided check)

Credit Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

\_\_\_\_\_ CVV Code \_\_\_\_\_

### Bank Account Information -

Bank Name: \_\_\_\_\_

Account# \_\_\_\_\_ Routing# \_\_\_\_\_

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### Office Use Only

\_\_\_\_\_ New Mbr Info          \_\_\_\_\_ Updating Info

Date \_\_\_\_\_ Staff Initials \_\_\_\_\_