



NATIONAL FEDERATION OF THE BLIND REQUEST FOR PRE-AUTHORIZED CHECK PLAN

* Required information. Incomplete forms cannot be processed.

Screen ID _____

(Check one) _____ Initial Enrollment _____ Other Change _____ Increase by \$_____ per month

* For my benefit and convenience, I hereby request and authorize the National Federation of the Blind to draw a check in the amount of \$ _____ (Total Contribution) on the _____ day of each month payable to its own order. This authorization will remain in effect until revoked by me in writing and until they actually receive such notice. (The PAC card must be signed at the two X's below). A voided check is required unless you fill out all banking information in the section below.

(PLEASE PRINT)

* Name _____

* Address _____

* Phone _____

X _____

(Name of Payor for whom checks are to be drawn; both signatures if two are necessary.)

MAIL TO: Treasurer
National Federation of the Blind
1800 Johnson Street Baltimore, Maryland 21230

AUTHORIZATION TO HONOR CHECKS DRAWN BY NATIONAL FEDERATION OF THE BLIND

We understand that your bank has agreed to cooperate in our Pre-Authorized Check Plan on behalf of your depositor. Attached is your client's signed authorization to honor such checks drawn by us.

* Name of Depositor as shown on Bank records: _____

* Routing No. _____ * Acct. No. _____

* Name of Bank, Branch Name, and address of the bank where account is maintained: _____

Customer's account and your bank transit numbers will be MICR printed on checks, per usual specifications, before they are deposited.

For my benefit and convenience, I hereby request and authorize you to pay and charge to my account checks drawn on my account by the National Federation of the Blind to its own order. This authorization will remain in effect until revoked by me in writing and until you actually receive such notice I agree that you shall be fully protected in honoring any such check.

In consideration of your compliance with such request and authorization, I agree that your treatment of each check, and your rights in respect to it shall be the same as if it were signed personally by me and that if any such check be dishonored, whether with or without cause, you shall be under no liability whatsoever.

Our Indemnification Agreement is printed below.

The National Federation of the Blind is instructed to forward this authorization to you.

* Signature of depositor(s) as shown on Bank records for account to which this authorization is applicable: _____

* Date _____

X _____

INDEMNIFICATION AGREEMENT

In consideration of your compliance with the request and authorization of the depositor named above.

THE NATIONAL FEDERATION OF THE BLIND

1. It will refund to you any amount erroneously paid by you to the National Federation of the Blind on any such check if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check on which such erroneous payment was made.

Authorized in a resolution adopted by the Board Members of the National Federation of the Blind on 11-28-74.

THE NATIONAL FEDERATION OF THE BLIND BY: _____