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| MEMBER ACCOUNT NUMBER | | |
|------------------------------|--|--|

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|------------------------------|-------------------------------|-------------------------------|-------------------|----------------|------------------|
| <input type="checkbox"/> Mr. | <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss | FIRST NAME | INITIAL | LAST NAME |
| <input type="checkbox"/> Ms | <input type="checkbox"/> Dr. | <input type="checkbox"/> Rev. | | | |

| | | | | | |
|----------------|-----------------|--------------------|------------------|-----------------------|------------|
| ADDRESS | | | AREA CODE | HOME TELEPHONE | |
| CITY | PROVINCE | POSTAL CODE | AREA CODE | BUS. TELEPHONE | EXT |

ACCOUNTS I WOULD LIKE TO PAY THROUGH THIS SERVICE

| OFFICE USE | COMPANY | ACCOUNT NUMBER |
|------------|---------|----------------|
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I hereby request the Bill Payment Service as offered by AcceleRate Financial to debit payments authorized by me from the account specified by me. Please refer to the Member Account Agreement for Terms and Conditions. We may contact you for verification for any future online requests to add a new vendor. Please be advised we will call you if your request cannot be added.

Authorized Signature(s)

Date