

Request for Social Security & Disability Payment Arrangements

Name (As shown on account) _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

Conditions of this Agreement:

1. Member must be on Social Security or Disability and receiving a check during the first week of each month.
2. Proof of age may be required.
3. Any account not paid by the deferred due date will no longer be eligible for the deferred program.

I hereby certify that I am eligible for the Social Security and Disability Program by virtue of the fact that I am currently receiving Social Security/disability benefits as a result of:

- ___ Age 62 or older
___ Total Disability

To receive information about our other payment options, place a check beside the programs listed below that interest you.

- Bank Draft Payment
 Credit Card Billing
 Levelized Billing

Signed: _____ Date: _____