Central Illinois Security, Inc.

DIRECT PAYMENT AUTHORIZATION FORM

ACCOUNT HOLDER INFORMATION

ACCOUNT HOLDER NAME: _____ S.S.N.: _____

JOINT ACCOUNT HOLDER NAME: _____ S.S.N.: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

FINANCIAL INSTITUTION INFORMATION

NAME OF FINANCIAL INSTITUTION: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

9 DIGIT ROUTING NUMBER: _____

ACCOUNT NUMBER: _____

I authorize **Central Illinois Security, Inc.** to initiate withdrawals from my account at the financial institution named in this application for payment of my **Central Illinois Security, Inc.** monitoring bills. This authorization will remain valid until either Central Illinois Security, Inc., my financial institution, or I revoke it.

I can suspend payment of a bill by notifying **Central Illinois Security, Inc.** no later than 1 week prior to the date that payment is scheduled to be deducted from my account. I understand that three or more suspensions in a 12 month period will result in cancellation of my participation in the Direct Payment program.

I understand that the Direct Payment program is an alternative method of payment only and does not otherwise affect my rights or the rights of **Central Illinois Security, Inc.** or my financial institution with respect to each other. I further understand that **Central Illinois Security, Inc.** and my financial institution reserve the right to terminate the Direct Payment plan and/or my participation in it. If I wish to discontinue my participation in the Direct Payment plan, I may do so by notifying **Central Illinois Security, Inc.**

_____ _____

Authorized Account Holder Signature Date

_____ _____

Joint Account Holder Signature Date