CROSS OVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

AUTOMATED GIVING PLAN

To enroll in the Automated Giving Plan, complete the information below and attach a voided check.

- Full Name: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Home:_____ Work: _____
- Phone: _____ Phone: _____
- E-mail: _____
- Gift Amount: _____ Start Date: _____
- Withdrawal date(s): _____5th _____20th _____Both dates

I hereby authorize an automatic debit on the day(s) of each month and in the dollar amount specified above, starting on the date shown above, from the account designated below. I may discontinue the use of this Automated Giving Plan at any time by giving notice at least 5 days before the next scheduled processing date. If I discontinue the use of the Automated Giving Plan, I may elect to restart at any time. I also understand that drafts returned for insufficient funds (NSF) will be presented a second time unless I notify Cross Over Ministry not to present them again.

_____ _____
Signature Date

_____
Name(s) on Account

- Bank Name: _____
- Bank Routing # (9 digits): __ __ __ __ __ __ __ __ __
- Account #: _____

Please use a separate form if you wish to give from more than one bank account

NOTE: If you bank at a Credit Union, you must verify with your institution the correct bank routing and account

Return this completed form along with your voided blank check to:
Development Manager
Administrative Offices
Cross Over Health Center
8600 Quioccasin Road, Suite 101
Richmond, VA 23229

Please call the Development Office at 804-655-2794 ext 102 if you have questions