AUTHORIZATION FORM

Health Care for All - Minnesota **ES11995**

FOR OFFICE USE ONLY	ENVELOPE/DONOR #	DATE

Effective date of authorization: _____

Health Care for All - Minnesota engages in lobbying; contributions are not tax deductible

Type of Authorization Form:
- ❑ New Authorization
- ❑ Change donation amount
- ❑ Change donation date
- ❑ Change banking information
- ❑ Discontinue electronic donation

❑ I will notify Health Care for All - Minnesota with any changes to my account

Last Name	First Name	
Address		
City	State	Zip

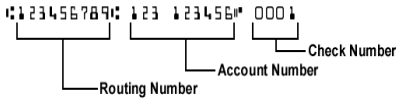
DATE OF FIRST DONATION:	FREQUENCY OF DONATION: (check only one)	DONATION AMOUNT:
_____/_____/_____	❑ Monthly on the 15th ❑ Quarterly (on the 15th of January, April, July, October) ❑ Annually ❑ One-Time on _____/_____/_____	$ _____

CHECKING / SAVINGS

Please debit my donation from my (check one):
- ❑ Savings Account (contact your financial institution for Routing #)
- ❑ Checking Account (staple a voided check below)

Routing Number: _____
Valid Routing # must start with 0, 1, 2, or 3

Account Number: _____



I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature:_____ Date:_____

CREDIT CARD

Please charge my donation to my (check one): ❑ Visa ❑ MasterCard ❑ Discover Card

Credit Card Number:	Expiration Date:

Name on Card:

Billing Address (if different from above):

I authorize the above organization to charge my credit card in accordance with the information above.

Signature (as it appears on the credit card): _____ Date: _____

Please staple voided check over credit card section above if using checking account.