LAKELAND CARE
Local. Compassionate. Dependable.

N6654 Rolling Meadows Drive
Fond du Lac, WI 54937
Phone: 920-906-5100
Toll-Free: 877-227-3335
Fax: 920-906-5103

Dear Lakeland Care Member,

For your convenience, Lakeland Care has an automatic payment program for bill payment. If you choose, payment of your monthly charges can be automatically withdrawn from your bank account. If you would like to pay by automatic payment, please fill out the enclosed authorization form and send the form to:

Lakeland Care, Inc.
Attn: Fiscal Department
N6654 Rolling Meadows Dr.
Fond du Lac, WI 54937

Once automatic payments begin, payments will be withdrawn from your bank account on the 10th or 23rd of each month. You will choose which withdrawal date on the application form. If the withdrawal date falls on a weekend or holiday, the withdrawal will occur on the next business day**.**

Please return the enclosed form and a blank voided check to Lakeland Care. These need to arrive at the Lakeland Care office at least one week prior to your preferred withdrawal date. Forms received less than a full week prior to the date will be effective the following month.

The payment withdrawn from your account will be the current charges as shown on your member obligation statement. If you have agreed to a payment plan, the payment withdrawn from your account will be the current charges plus the additional payment plan amount as agreed.

If you have any questions or concerns, please contact the Accounts Receivable Associate at (877) 227-3335.

Sincerely,

Lakeland Care Fiscal Department

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Authorization Form – for automatic withdrawal of monthly charges from designated bank account.

AUTHORIZATION AGREEMENT –FOR PRE-ARRANGED PAYMENTS (ACH DEBITS)	
Member Name	6 Digit Lakeland Member ID
I (we) hereby authorize **Lakeland Care, Inc.** hereinafter called COMPANY, to initiate debit entries to my (our) checking or savings account indicated below and the depository (bank) named below, hereinafter called DEPOSITORY, to debit the same to such account.	
Depository (Bank) Name Branch	9 Digit Routing Number
City State Zip	Account Number Account Type ☐Checking ☐Savings
This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) has the right to stop payment of a debit entry by notification to DEPOSITORY at such time as to afford DEPOSITORY a reasonable opportunity to act on it prior to charging account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by DEPOSITORY, provided I (we) send written notice of such debit entry in error to DEPOSITORY within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first.	
Name (Please Print)	Date
Signature	
Relationship to Member	Phone Number

Withdrawal Date (please check one) ☐10th ☐ 23rd

Month Withdrawal to Begin: Month Year
(Please allow a minimum of 1 week after the form is received for auto payments to begin.)

Please Enclose a Blank Voided Check

Please send authorization form along with a blank voided check to:
Lakeland Care, Inc.
Attn: Fiscal Department
N6654 Rolling Meadows Dr.
Fond du Lac WI 54937
Fax-920-906-5103

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July 2020