

**PETERS TOWNSHIP  
SANITARY AUTHORITY**

111 BELL DRIVE McMURRAY,  
PA 15317-3415 PHONE:  
724-941-6709 FAX: 724-941-2283  
Web Site: ptsaonline.org  
Email: ptsageneral@ptsaonline.org



Enoch E. Jenkins, Manager  
Mark A. Chucuddy, Operations Manager  
Patricia L. Mowry, Financial Controller  
Natalie Waggoner, Billing Specialist  
Faye E. Abbondanza, Admin. Assistant

**AUTHORIZE FOR AUTOMATIC PAYMENT  
WITHDRAWAL (ACH) FOR QUARTERLY PAYMENTS**

Thank you for requesting automatic payment withdrawal for your Peters Township Sanitary Authority sewer account. With this process, a quarterly payment will be withdrawn from your bank checking account or savings account, automatically on the due date specified on the bill. Please allow thirty (30 days) following receipt of this authorization for the auto pay processing to begin. Continue to pay your bill as usual until there is a notice on the bill indicating that an automatic payment transaction will be created to pay this bill.

ANY CHANGES TO OR DISCONTINUATION OF THIS WITHDRAWAL SCHEDULE MUST BE REQUESTED AT LEAST TEN (10) WORKING DAYS PRIOR TO THE DUE DATE SPECIFIED ON YOUR BILL AND MUST BE MADE IN WRITING.

If there are insufficient fund in the account to complete the withdrawal, there will be a \$50 fee assessed to cover our bank account.

\* A separate authorization agreement must be completed for each account that automatic payment withdrawal is requested.

**Customer Information**

Customer Name \_\_\_\_\_ Account Number \_\_\_\_\_  
Billing Address \_\_\_\_\_ Service Address \_\_\_\_\_  
(If different than billing address)  
City, State, Zip Code \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_  
Contact Phone No. \_\_\_\_\_ Email \_\_\_\_\_

**Bank Information**

Financial Institute \_\_\_\_\_ Name (s) on Bank Account \_\_\_\_\_  
Account No. \_\_\_\_\_ Route No. \_\_\_\_\_  
Checking \_\_\_\_\_ or Savings \_\_\_\_\_

**PLEASE ATTACH A VOIDED CHECK OR DEPOSIT SLIP WITH THIS APPLICATION AND MAIL TO PTSA 111 BELL DRIVE MCMURRAY, PA 15317**

**\*\* AUTHORIZATION AGREEMENT \*\***

I (we) hereby authorize the financial institute designated in this application to charge the account specified above payment of my service. I (we) understand that a fee will be charged to my account for each automatic payment request return. If two authorization request are returned, I (we) will be excluded from further participation in the plan. In addition, I (we) understand that reserves the right to terminate this payment plan and/or my (our) participation therein.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

OFFICE USE ONLY

Date Received \_\_\_\_\_ Date Entered \_\_\_\_\_ Letter Sent \_\_\_\_\_

*"This Authority is an Equal Opportunity Provider"*