ANDERSON COLLEGE
OF HEALTH, BUSINESS AND TECHNOLOGY
YOUR TRAINING. YOUR CAREER. YOUR FUTURE.

PRE-AUTHORIZED PAYMENT AGREEMENT

Cardholder Name: _____

Address: _____ Apt #: _____City/Town: _____

Province: _____ Postal Code: _____Phone Number: _____

PLEASE PRINT CLEARLY
CREDIT CARD NUMBER: | | | | | | | | | | | | | | | | |

EXPIRY DATE: | | | | | **CVV CODE:** | | | |

M M Y Y

☐ **VISA** ☐ **MASTERCARD**

Please refer to your payment schedule in your registration contract for dates of debit.

I AUTHORIZE ANDERSON COLLEGE TO DEBIT THE CREDIT CARD ACCOUNT PROVIDED FOR ALL AMOUNTS OWED ON THE DATES STATED ACCORDING TO THE PAYMENT SCHEDULE. I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OF THE PRE-AUTHORIZED PAYMENT AGREEMENT.

_____ _____

NAME (Please Print) Signature of Account Holder

_____

Date

We ensure complete confidentiality in accordance to our policies with students' files and provided information. Pre-authorized Payment Agreement can be terminated by verbal notification to our Financial Assistance Department and another method of payment must be provided in order to keep your account up to date.

FOR STUDENT SERVICES TO COMPLETE CHANGE OF PAYMENT WITHDRAWAL

1. Amount: _____ Due: _____
2. Amount: _____ Due: _____
3. Amount: _____ Due: _____
4. Amount: _____ Due: _____
5. Amount: _____ Due: _____
6. Amount: _____ Due: _____
7. Amount: _____ Due: _____
8. Amount: _____ Due: _____
9. Amount: _____ Due: _____
10. Amount: _____ Due: _____
11. Amount: _____ Due: _____
12. Amount: _____ Due: _____
13. Amount: _____ Due: _____
14. Amount: _____ Due: _____
15. Amount: _____ Due: _____
16. Amount: _____ Due: _____
17. Amount: _____ Due: _____
18. Amount: _____ Due: _____