DEALER FUNDING

AUTHORIZATION FOR MONTHLY RECURRING ACH DEBIT TO A CHECKING ACCOUNT

Customer Name(s): _____ Date: _____

Account Number: _____

Please complete and return this form if you would like to make your monthly scheduled payments via ACH.

I/we authorize DEALER FUNDING, LLC to initiate DEBIT entries from my/our Checking Account at the named depository financial institution below. If a payment is rejected by my/our financial institution for any reason, including without limitation insufficient funds, I/we understand that DEALER FUNDING, LLC may at its discretion attempt to process the payment again within 30 days, and I/we authorize DEALER FUNDING, LLC to make a one-time electronic fund transfer from my/our account to collect a returned payment fee of $10.00. I/we also authorize DEALER FUNDING, LLC to initiate ACH entries to correct any erroneous payment transaction. I/we acknowledge that the origination of ACH transaction to my/our account must comply with the provisions of the US law and the Rules of the National Automated Clearing House Association (NACHA).

BANK NAME: _____ ****Attach a Voided Check to this form ****

BANK BRANCH ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ROUTING NO: _____ ACCOUNT NO: _____

RECURRING TRANSACTION DATE: _____ BEGINNING DATE: _____

RECURRING TRANSACTION AMOUNT: $_____

If any payment date described above falls on a weekend or holiday, I/we understand that the payment may be executed on the next business day.

This authorization will remain in full effect until my/our credit obligation to DEALER FUNDING, LLC has been paid in full, or DEALER FUNDING, LLC has received written notification terminating this authorization at the address set forth below. I/we agree to notify DEALER FUNDING, LLC in writing of any changes in my/our account information or termination of this authorization at least 15 days prior to the next scheduled payment due date. This advance notification affords DEALER FUNDING, LLC a reasonable opportunity to act on it. I/we request the financial institution that holds my/our account to honor all payments initiated in accordance with this authorization form.

Name on Bank Account: _____(If joint account, both names are required)

Name on Bank Account: _____

Address: _____

(List the address as it appears on file with your financial institution)

Signature: _____(If joint account, both names are required)

Signature: _____

Please Return To:

Secure Fax Line (877) 351-1525 or mail to P.O. Box 888759, Atlanta, GA 30356