

AUTHORIZATION OF AUTOMATIC PAYMENT

I authorize Alliance and the bank named below to initiate entries to my checking/savings account. This authority will remain in effect until I notify you in writing to cancel it, and the telephone company has confirmed to me that it has been terminated. I am aware that any credit due my account must be approved by the appropriate telephone company personnel and will appear as a credit on the next monthly billing after the credit has been approved.

Alliance reserves the right to cancel my use of the Automatic Payment Plan.

Mail this form to:

*Alliance Communications
PO Box 349
Garretson, SD 57030.*

Name of Financial Institution: _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Signature 1: _____ **Date:** ____/____/____
(if account is in two names, both must sign)

Signature 2: _____ **Date:** ____/____/____
(if account is in two names, both must sign)

Name (please print): _____

Address (please print): _____

Telephone: (____) ____ - _____

Monthly Withdrawal Date:

10th 15th 20th No Preference

Checking Account No.: _____
(Attach voided check below)

OR

Savings Account No.: _____
(Attach savings account deposit slip below)