ENT OF SOUTHEASTERN CT

Credit Card Authorization Form

DATE:_____

NAME:_____

ACCOUNT NUMBER:_____

I authorize ENT OF S. EASTERN CT to automatically charge $_____ per month to my credit card in payment of my balance due. The charge will be made on the _____day of each month.

CARD TYPE: (Please Circle One)

VISA ◯ MASTER CARD ◯

NAME OF CARDHOLDER_____

CARD NUMBER:_____

EXPIRATION DATE:_____

_____
SIGNATURE