AUTOMATIC PAYMENT AUTHORIZATION FORM

I authorize **Larsen Supply Company** and my financial institution named below to initiate electronic entries to the account identified on this form. This authority will remain in effect until I notify you in writing. I will do so 30 days prior to cancellation so as to afford the financial institution a reasonable opportunity to act on my request.

_____ _____

Company Name (please print)

_____

Address City State Zip Code

_____

Name of Financial Institution

_____

Address of Financial Institution City State Zip Code

Account Type: Checking _____ Savings _____

Bank Account No:

Bank Routing No:

I agree with the terms and conditions of this service and verify that the above information is accurate and true. I understand that I may cancel this service at any time by giving a 30 day written notice.

_____ _____

Signature Date

_____

Printed Name Title