

SecurityTrax Auto Pay Authorization Form

Date: _____

Company Name ("Client"): _____

Billing Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____

PLEASE COMPLETE THE APPROPRIATE SECTION BELOW – PLEASE PRINT CLEARLY

Credit Card

Card Number: _____

Card Expiration: _____

Card Type (circle one): Visa MasterCard American Express

Name on Card: _____

I hereby authorize SecurityTrax LLC to use the above information for collecting automatic payments for services rendered. I verify that the information provided is owned by Client and that I am authorized to approve the use of this account in this manner.

By: _____
(Signature)

Name Printed: _____

Title: _____

Fax Completed Form To: (801) 504-9200

Email: billingdept@securitytrax.com