



# NATIONAL FEDERATION OF THE BLIND PRE-AUTHORIZED CONTRIBUTION

Welcome to the National Federation of the Blind's Pre-Authorized Contribution (PAC) program. Your donation will help the blind live the lives they want. By providing your financial information and signing this form, you are agreeing that once a month the National Federation of the Blind may deduct the amount you specify from your checking account or charge your credit card the amount you indicate. All fields for your preferred donation method and authorizing signature are required.

**Check one**    New Enrollment    Change                       Increase   or    Decrease \$ \_\_\_\_\_ per month

Tell us how you would like your PAC Plan recognized — name and state:

Name(s): \_\_\_\_\_ State: \_\_\_\_\_

Mailing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

### Bank Account Information *(please attach a VOIDED check)*

Name on Account \_\_\_\_\_

Amount to Withdraw \$ \_\_\_\_\_

Bank Routing Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Checking Account Number \_\_\_\_\_

Bank Name \_\_\_\_\_

Withdraw Date *check one*                       10th   or    20th

### Credit / Debit Card Information

Name on Card \_\_\_\_\_

Billing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Amount to Charge \$ \_\_\_\_\_

Credit Card Number \_\_\_\_\_

Expiration MM/YY \_\_\_\_\_ CVV Code \_\_\_\_\_

Processing Date *check one*                       10th   or    20th

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return to:** Treasurer, National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230 **E-mail:** [accounting@nfb.org](mailto:accounting@nfb.org)