

# REGULAR GIVING FORM

## Automatic Payment Authority for Regular Giving



To the Manager

Name of Bank

Branch Address

Please start / amend the following Automatic Payment:  New Payment  Change existing payment

Name of Account

Account Number

Payer Reference (to appear on our statement)

Amount \$

Start/Change date  /  /

Frequency  Weekly  Fortnightly  4 Weekly  Quarterly  Annually

Pay to **Multiple Sclerosis Society of Auckland & the North Shore Inc.**

Account Number **123047 0088939 00**

Payee Reference  Regular Gift ID Number   
*(this will be completed by MS Auckland Region)* *(this will be completed by MS Auckland Region)*

Signature  Signature

Date  /  /  Date  /  /

Name  (Mr/Mrs/Miss/Ms)

Address

Telephone (  ) E-Mail

Reason for choosing to donate to MS Auckland Region \_\_\_\_\_

Please return this completed form to:  
MS Auckland Region  
PO Box 16275, Sandringham, Auckland 1351

### Thank you for your support

Charities Commission No. CC10863