



OVERPAYMENT REFUND REQUEST

Date of Request: _____

Account Number: _____

Payment Date: _____

Account Holder Name: _____

Credit Card Account Holder Name: _____

Service Address: _____

Refunds by check should be mailed to: _____

Payment Type:

Cash

Check

EFT

MasterCard

Visa

(Check One)

Street

City

State

Zip

Payment Amount : \$ _____

Last four digits of credit card used: _____

Refund Amount: \$ _____

Or, original check number used: _____

REASON FOR REFUND REQUEST:

Please read each of the following statements and check the box to the left to indicate that you have read and agree to the terms of this refund request. **Your refund will not be processed unless all boxes are checked.**

I understand my request may alter the amount due on my current statement and or next statement period.

I understand that this request will be calculated based on the information I have provided. I also understand that I am responsible for the repayment of all charges that may be identified at a later date.

My signature below indicates that I have read and agree to the terms and conditions of the request.

Signature: _____