



CCOF

Organic Certification Education & Outreach Political Advocacy Promotion

CCOF Certification Services LLC Payment Plan Agreement

Operation Name: _____

Account #: _____

Payer's Full Name: _____

Payer's e-mail Address: _____

Payer's Daytime Phone Number: _____

PAYMENT PLAN GUIDELINES: It is advisable to have your account balance paid in full before you incur any additional charges. While deciding the number of payments you wish to make, please consider when your next inspection and/or annual fees will come due.

If you need assistance setting up the payment plan, please contact the accounting department and we will be happy to help you.

\$ _____

Total Due on Account:
(**not including service fee of \$20-)

****Please add the \$20- administration fee to your first payment.**

***I would like to make:**

3 4 5 6 7 8 9

Monthly Payments of: \$ _____
(Total Due divided by # of months = your monthly payment)

Each month until: _____
(Date total will be paid in full)

Terms and Conditions:

I agree to enroll in the CCOF Payment plan by completing, signing, and returning this application and contract with a one-time nonrefundable administration fee of \$20.00 and any installment payment due. I understand that all payments are due by the due dates shown on the invoices. I also understand if I do not make a payment, I will begin to accrue finance charges at a rate of 18%.

I understand a Noncompliance for nonpayment and \$150 late fee may be issued when a payment plan installment is more than 30 days past due for a payment plan that includes an invoice with an original due date over 90 days past due.

I understand that this agreement is only applicable for the open invoices included in the "total due on account" line as of today. Any future invoices where I wish to request a payment plan; I must send a new form that will need to be approved by the President.

CCOF shall have the right to terminate my participation in the plan and declare the entire unpaid balance on the account payable immediately if I fail to pay any installment within thirty (30) days of the due date. I understand that if I default, I forfeit my right to participate in this plan at a future date.

I agree to the terms and conditions of this plan:

Signature: _____

Date: _____

*Please mail or fax this sheet to CCOF at: 2155 Delaware Avenue, Suite 150 Santa Cruz, CA 95060
FAX : (831) 423-4528.*

FOR OFFICE USE ONLY: APPROVED: _____ (CCO) _____ (ACCOUNTING) ENTERED: _____ BILLED: _____

02/22/2018

Page 1 of 1

