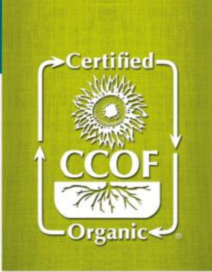

CCOF

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

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 non*refundable administration fee of $20.00 and any installment payment due.** *I understand that all payments are due on the first day of each month a payment is due. I also understand if I do not make a payment, I will begin to accrue finance charges at a rate of 18%.*

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 Certification Director.

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 fifteen (15) 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: ________

2155 Delaware Avenue, Suite 150, Santa Cruz, CA 95060 • (831) 423-2263 • fax (831) 423-4528 • ccof@ccof.org • www.ccof.org