EXHIBIT 1

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS (ACH DEBITS)

CHECK ONE:

ADD (New Preauthorized Debit Participant) (Financial Institut		CHANGE on and/or Acco	DELETE (Cancel Participation in the Program)							
NOTE: Due to the time required for company and bank processing, please allow one or two weeks for processing.										
I (we) hereby authorize										
DEL GOLLOKTI INAMOIAE INOTTION										
CITY	STATE				ZIP CODE					
TRANSIT ROUTING NUMBERS ACCOUNT NUMBER INFORMATION										
1:	l:									
☐ CHECKING	☐ SAVINGS									
This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.										
Please attach a voided check or deposit slip for account validation.										
NAME/BUSINESS NAME (if applicable)	- Please Print									
ADDRESS	CITY/STATE			ZIP CODE						
SIGNED	1			DATE						

THIS FORM IS TO BE RETAINED BY THE COMPANY AS A MATTER OF RECORD