Player Full Name:

Age: U-

Gender: M F (circle one) Player’s DOB / /

Parent Full name:

Credit Cardholder Full Name:

Cardholder Signature:

Billing Address:

City:

State: Zip:

Phone #:

Circle One: Visa MasterCard

Credit Card Number:

Exp. Date:

CSV#:

One-time dollar amount to be charged:

Monthly dollar amount to be charged (if setting up payment plan card will be charged on the 1st of each month until balance paid in full):

United Soccer Alliance of Indiana will charge your credit or debit card the appropriate deposit upon receipt of this form.

By agreeing to this form and your signature above you are authorizing United Soccer Alliance of Indiana to charge your credit/debit card on or before the 1st of each scheduled month the amount designated to be charged. You also agree to the payment plan as described in this document. You may cancel this agreement at any time in writing.

By agreeing to this form and your signature above you have completely read United Soccer Alliance of Indiana re-fund and injury policy.

In event your credit/debit card is denied at any point your child’s playing privilege will be suspended until all

balances are current.

Return form to:   
United Soccer Alliance of Indiana   
PO Box 532472

Indianapolis, IN 46253