Community Bank
Overdraft Privilege Opt-Out Form

Depositor Name:

_____

Depositor Address:

_____

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Depositor Account Number:_____

(This form is in response to your request to opt-out of a service provided by Community Bank. ("bank"). However, you may periodically continue to receive information about this service).

By opting out of Overdraft Privilege, I understand that any and/or all of my insufficient fund checks may be returned to the Payee, and I agree to hold the bank harmless, and without liability, for any Payee fees or other consequences that may result from this action. The bank will continue to charge its $35.00 return item fee for any transactions presented to the bank drawn on insufficient funds.

If this is a joint account, I agree that the signature of only one accountholder is necessary for the bank to suspend the Overdraft Privilege.

I (we) have the right to reinstate this program at any time on the condition I (we) provide them the request to do so in written documentation and qualify for the service.

_____

Depositor Signature **Date**

_____

Joint Account Owner Signature **Date**

Please complete this form and return it to us AS SOON AS POSSIBLE either in person or by mail:

Or via fax:
(731) 968-7224

Community Bank
P.O. Box 710
Lexington, TN 38351