Direct Deposit Authorization Agreement

FAX completed form to: 866-483-3313

☐ New Agreement ☐ Change Account ☐ Cancel Agreement

I hereby authorize my Employer to initiate credit or debit entries to my account with the Financial Institution indicated below. This authority is to remain in full force and effect until my Employer has received written notification from me of its termination in such time and in such manner as to afford my Employer and the Financial Institution a reasonable opportunity to act on it.
Please verify that your bank has received the authorized ACH transfer before making payments from your account. My Employer. is not responsible for returned checks issued by the Employee.

Type of Account: ☐ Checking ☐ Savings

Financial Institution:

Name: ________________________ Branch: ____________________________

City: _____________________ State: ___________ Zip Code: _____________

Transit/ABA No. _____________________ Account No. ____________________

Employer: ____

Employee:

Name: ____________________________ Social Security No. _____-___-_____

Date: ___________ Signature: ____

Attach: Personal check with the word "VOID" written on its face for checking accounts OR savings deposit slip for savings accounts. Form will not be processed without information below

Jane A. Doe
1000 Main St.
Anywhere, USA 10001

3680

Date______________

PAY TO THE
ORDER OF____ $ [ ]

____ DOLLARS

MEMO________________________ X____________________________

⑆ 123456789 ⑆ 11484620040 ⑈ 3680

Transit/ABA No. Account No.