DIRECT DEPOSIT AUTHORIZATION FORM

Employer Name

Participant First Name **MI** **Last Name**

Address

City **State** **Zip**

Email Address

Social Security Number **Phone Number**

Please check one:		
☐ **Set up new Direct Deposit**	☐ **Change Direct Deposit**	☐ **Cancel Direct Deposit**

Authorization Agreement for Direct Deposit Reimbursement

Bank Account Information:

Type of Account: (Please check one)

☐ **Checking** You must attach a ***voided check*** with pre-printed MICR account information, or a *letter or form* from the Bank certifying the ABA number, Account number and MICR information.

☐ **Savings** You must attach a ***letter or form*** from the Bank certifying the ABA number, Account number and MICR information.

Name of Bank: _____

Transit ABA Routing #: _____ **Account #:**_____

(***Please allow 10 business days after receipt by Capital Financial Group, Inc. for bank pre-notification to be complete***)

- **Direct Deposit is available only if your employer uses Electronic Funds Transfer.**
- **Please be sure to provide your SSN or Member ID.**
- **Mail to: Capital Financial Group, Inc.**
  89 Saratoga Avenue
  South Glens Falls, New York 12803
  Or fax to: (518) 798-7502
- **Call Capital Financial Group, Inc. with questions at (518) 793-2885**

By submitting this form, I hereby authorize Capital Financial Group, Inc. to deposit my reimbursements directly into the bank account indicated above and, if necessary, to withdraw amounts from the account in order to adjust for any amounts erroneously deposited. This authorization will remain in effect until Capital Financial Group, Inc. receives written notice from me of its termination.

_____ _____

Participant Signature **Date**