☐ **PLEASE CANCEL THIS ACCOUNT AND REMOVE IT FROM MY PROFILE.**

Authorization Agreement for Direct Deposit

I (we) hereby authorize Gifted Healthcare/RMRG, hereinafter called COMPANY, to initiate credit entries to my (our)

☐ Checking ☐ Savings ☐ Pay Card

Account(s) indicated below and the bank named below, hereinafter called DEPOSITORY, to credit the same to such account.

Depository Name (BANK NAME): ____

City: ____________________________ State: ____________________________ Zip________________

Routing Number: ____

Account Number: ____

In the event of error, I authorize my bank/financial institution to initiate a reversal in the amount of the error to my account.

Direct Deposit time cards must be submitted by 1:00 pm daily or they will be processed the following day. Your funds will be available 48 business hours, excluding holidays from the date it is processed. The Federal Reserve banking system requires two complete business days to guarantee this type of direct funds transfers. Dependent on your banking institution, your funds may be available sooner.

This authority is to remain in full force and effect until COMPANY has received written notification from me (us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name: ____
(please print)

Signed: ____ Date:_____________________________

****** ATTACH VOIDED CHECK OR BANK LETTER VERIFYING ACCOUNT AND ROUTING NUMBER *****