Authorization Agreement for Direct Deposit of Payroll

I (we) hereby authorize Health Consultants of Virginia, Inc. to initiate Direct Deposit of Payroll entries or corrections to my (our) ☐ checking ☐ savings account indicated below and the financial institution named below to credit the same to such account.

____

FINANCIAL INSTITUTION

____

CITY STATE ZIP CODE

____

BANK TRANSIT / ABA NUMBER (9 digits) ACCOUNT NUMBER

This authority is to remain in full force and effect until Health Consultants of Virginia, Inc. has received written notification from me of its termination in such time and in such manner as to afford them a reasonable opportunity to act on it.

____

NAME (S) SOCIAL SECURITY NUMBER

______________________________ ______________________________

SIGNATURE DATE SIGNATURE DATE

******Please attach a VOIDED CHECK so that the company can verify the receiving bank information.***