

**Direct Deposit of Payroll / Authorization Agreement for Automatic Deposits**

Healthcare National Marketing Inc.

Company / Employer Name

\_\_\_\_\_  
Company ID Number

I authorize the above Company and the Financial Institution listed below to electronically deposit my net pay to the specified account each payday. (circle one)    CHECKING    SAVINGS

\_\_\_\_\_  
Bank Name

\_\_\_\_\_  
Branch

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Bank Transit / ABA Number

\_\_\_\_\_  
Account Number

If monies to which I am not entitled, are deposited to my account, I authorize my EMPLOYER to direct the Financial Institution to return said funds. This authority will remain in effect until I have filed a new authorization, or until revoked by me in writing, or upon termination of my employment with said COMPANYY.

\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
ID Number

X

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please fill out this form then print and sign it. Once completed, fax this form as well as a copy of a blank check for Checking Account deposits or a copy of a Deposit slip for Savings Account deposits to Healthcare National Marketing Inc. at 727 816 9057**