PREMIER *medical group*

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **Premier Medical Group of the Hudson Valley, PC** to initiate automatic deposits to my account at the financial institution named below. I also authorize **Premier Medical Group of the Hudson Valley, PC** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Premier Medical Group of the Hudson Valley, PC** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Premier Medical Group of the Hudson Valley, PC** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Human Resources Department.

Name of Employee: _____

I wish to deposit:

☐ Remainder of Net Pay

☐ Specific Dollar Amount:

$_____.00

Account Information #1

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking ☐ Savings ☐

Account Information #2

Name of Financial Institution: _____

Routing Number: _____ Checking ☐ Savings ☐

Account Number: _____

☐ **I do not wish to participate in Direct Deposit.**

Signature

Authorized Signature: _____ **Date:** _____

Please attach a voided check and return this form to the Human Resources Department.