FHS DIRECT DEPOSIT AUTHORIZATION AGREEMENT

I hereby authorize Financial Health Services, LLC ("FHS") to initiate credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my account with the financial institution listed below (the "Account"). This agreement authorizes the financial institution holding the Account to post all such entries. This agreement and authorization will remain in full force and effect until FHS receives written notification from me of its termination and until FHS and my financial institution have a reasonable opportunity to act on it. I accept responsibility for notifying FHS of any changes in the status of the Account and acknowledge and agree that any such changes may result in direct deposit delays.

Further, I agree not to hold FHS 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 the Account. This paragraph shall survive any termination, cancellation or expiration of this agreement.

By signing below, I also acknowledge and agree that I have read and understand the Direct Deposit Instructions for Caregivers.

Select one: ☐ Checking Account ☐ Savings Account

Financial Institution:

Name:_____ Branch:_____

City:_____ State:_____ Zip Code:_____

Routing/ABA No._____ Account No._____

Signature:_____ **Date**:_____

Name: (please print clearly)_____

Phone Number_____ Social Security Number_____

Please attach a voided check or savings deposit slip for the Account here.
This request cannot be processed without one of these forms.