



Republic Health Resources, LLC

Direct Deposit Agreement Form

Employee's Name: _____

Authorization Agreement

I hereby authorize Republic Health Resources, LLC to initiate automatic deposits to my account at the financial institution named below. I also authorize Republic Health Resources, LLC to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Republic Health Resources, LLC 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 Republic Health Resources, LLC receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information 1

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking | Savings

All _____

Account Information 2

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking | Savings

Amount to be deposited _____

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a voided check or deposit slip and return this form to the Payroll Department.