



DIRECT DEPOSIT AUTHORIZATION

Print all information completely and accurately. Please verify your ABA Routing Number

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

Voided check(s) for Checking Account(s)

Deposit Slip(s) for Other Accounts

Enrollment Cancellation Change Request (Check appropriate box(es) below:)

Financial Institution Account Type

Account # Add New Account

PLEASE ALLOW UP TO THREE (3) WEEKS TO ACTIVATE ALL NEW DIRECT DEPOSITS AND/OR ACCOUNT CHANGES

I hereby authorize **Maxim Healthcare Services ("Maxim")** to initiate electronic credit entries and, if necessary, debit entries and/or adjustments for any credit entries made in error into the account(s) at the financial institution(s) named below. I authorize these financial institution(s) to credit these deposits to my account(s) and to debit my account(s) for any credit errors. This authorization will remain in effect until I notify **Maxim** in writing, using a Direct Deposit Authorization form, of the cancellation or change. I understand it is my responsibility to verify that the funds are in my account correctly prior to drawing on these funds and to notify **Maxim** of any discrepancies within 48 hours after the scheduled pay date. I understand that it may take up to three business days for the funds to be deposited into my account. I hereby agree to hold the company harmless from any errors or omissions the company may make in depositing or failing to deposit the funds to the designated account(s) resulting from incomplete or incorrect information on this Authorization Form. I understand that it is my responsibility to immediately notify **Maxim** should I close any of the account(s) listed below. I hereby hold harmless **Maxim Healthcare Services** for any and all fees and/or charges I may incur resulting from the crediting or debiting of funds to a closed account or should I draw on these funds before verifying the deposit.

Signature: _____

Date: _____

DIRECT DEPOSIT ACCOUNTS

Print Name: _____ <small>First /Middle Initial /Last</small>	Social Security #: _____
Branch Number/Name: _____	Employee Type: <input type="checkbox"/> Internal <input type="checkbox"/> External

FINANCIAL INSTITUTION (BANK) INFORMATION

Please verify the ABA Routing Number and Checking/Savings Account Number(s) with your financial institution. The employee is responsible for the accuracy of the ABA Routing number. Please attach a voided copy of a check for each checking account.

ACCOUNT #1 (Please attached a voided check for Checking Accounts/Deposit Slips for savings accounts)

ABA Routing Number: _____	Account Number: _____
Type of Account: (Check Only One Box) <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Amount of Deposit: <input type="checkbox"/> Full Amount of Check <input type="checkbox"/> Partial Deposit of : \$ _____
Financial Institution: _____ <small>(Name of Bank)</small> _____ <small>(Telephone Number)</small>	

ACCOUNT #2 (Please attached a voided check for Checking Accounts/Deposit Slips for savings accounts)

ABA Routing Number: _____	Account Number: _____
Type of Account: (Check Only One Box) <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Amount of Deposit: <input type="checkbox"/> Full Amount of Check <input type="checkbox"/> Partial Deposit of : \$ _____
Financial Institution: _____ <small>(Name of Bank)</small> _____ <small>(Telephone Number)</small>	

ACCOUNT #3 (Please attached a voided check for Checking Accounts/Deposit Slips for savings accounts)

ABA Routing Number: _____	Account Number: _____
Type of Account: (Check Only One Box) <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Amount of Deposit: <input type="checkbox"/> Full Amount of Check <input type="checkbox"/> Partial Deposit of : \$ _____
Financial Institution: _____ <small>(Name of Bank)</small> _____ <small>(Telephone Number)</small>	