Direct Deposit Form

The Accounting Department has been requested by the Banking Association to maintain a signed statement on file authorizing Core Medical Group, Inc. to electronically transfer payroll funds to your account. Please complete, date and sign.

Employee Name: _____ Date: _____

➔**Address to mail 1st two LIVE Checks**: _____
Street, City, State, Zip

➔**Address to mail stubs:** _____
Street, City, State, Zip

Note: if you want your checks/stubs to go to your temporary address while on assignment but don't yet know the address, please just indicate "TEMP" and be sure to submit your temporary address in writing prior to your assignment start date.

BREAK IN SERVICE MORE THAN 30 DAYS (MUST RETURN FORM): If you had direct deposit on a previous assignment, but had a break in service of more than 60 days, you must return this form and indicate one of the following:

☐ **Continue my previous direct deposit to Account #**_____
☐ **Add new direct deposit account** (fill out "new direct deposit accounts" section)

REPLACING A DIRECT DEPOSIT ACCOUNT:

☐ Cancel Direct Deposit Account #_____ EFFECTIVE IMMEDIATELY
☐ Cancel Direct Deposit Account #_____ After New Account is Set-Up (Fill out below)

TO SET UP ALL NEW DIRECT DEPOSIT ACCOUNTS: If depositing your entire check into the first account, you may write "FULL" in the amount. If depositing into more than one account, one account must list an exact dollar amount, and you may write "BALANCE" in the other amount section.

First Direct Deposit Account

☐ New Direct Deposit ☐ Change To Account ☐ Cancel

Savings Account ☐ Checking Account ☐ AMOUNT TO BE DEPOSITED: $_____

Bank Name _____ Branch Location _____

Bank ABA/Transit#_____ Bank Account _____

Second Direct Deposit Account – Balance Remaining after First Direct Deposit (Leave blank if full amount deposited to 1st account)

☐ New Direct Deposit ☐ Change To Account ☐ Cancel

Savings Account ☐ Checking Account ☐ AMOUNT TO BE DEPOSITED: $_____

Bank Name _____ Branch Location _____

Bank ABA/Transit#_____ Bank Account _____

- **Direct Deposit set up and account changes take between 2-3 pay periods to set up.**
- **You will be paid your weekly pay check via paper check or Global Cash Card until set up is completed.**
- **For new direct deposits, a voided check with name and address is required and must be attached to this form.**

AUTHORIZATION

I hereby authorize and request Core Medical Group, Inc., hereinafter referred to as "Company", to make payment of any amount owed to me by initiating credit entries or adjustment entries to my account(s), as indicated above, to the Banking Institution named above, hereinafter referred to as "Bank". I authorize and request said "Bank" to accept any credit entries or adjustment entries indicated by "Company" to such account(s), and to enter the same to such account(s), without responsibility for the correctness thereof.

It is understood that I may terminate this agreement at any time by written notification to the "Company" and to the "Bank". Any such notification to "Company" shall be effective only with respect to entries initiated by "Company" after receipt of such notification and a reasonable opportunity to act on it. Any such notification to "Bank" shall be effective only with respect to entries credited to my account(s) by "Bank" after receipt of such notification and a reasonable time to act on it.

Joint Account: If the account you select is a JOINT ACCOUNT, ***both parties must execute their signature indicating acceptance.***

_____ _____
Employee Signature Date

_____ _____
Joint Account Signature Date

2 Keewaydin Drive, Salem, NH 03079 Voice: 603-893-4515 800-995-2673 Fax: 603-893-8442