DIRECT DEPOSIT AUTHORIZATION

Company: **Coastal Clinical & Management Services, Inc. (CCMS)**

I. Action

☐ New Enrollment ☐ Change to Enrollment ☐ Termination of Enrollment

II. Employment Information

Employee Name (Please Print) _____

Social Security Number _____-_____-_____

III. Banking Information

Bank Name _____ Branch _____

City _____ ST ____ Zip _____

ABA Routing/Transit Number ☐:☐☐☐☐-☐☐☐☐-☐☐:

Type of Account: ☐ Checking Account ☐ Savings Account

Employee's Account Number: _____

IV. Agreement/Authorization

I (We) hereby authorize CCMS, hereafter called Company, to initiate credit entries to my (our) account indicated above and the Financial Organization named above, hereafter called Receiving Bank to credit the same to such account. Charges to said account initiated by Company may only be made to reverse credit amounts erroneously posted. This authorization is to remain in full force and effect until Company has received written notification from me of its termination in such time and in such manner as to afford Company and Bank a reasonable opportunity to act on it.

_____ _____

Employee Signature Date

_____ _____

Alternate Signature for Joint Account Date

YOU MUST INCLUDE A COPY OF A VOIDED CHECK IN ORDER TO PROCESS

If you are unable to provide a copy of a voided check, we may still process your request upon your acknowledgement that CCMS will not be held responsible for any entry of your banking information based on the information on this form alone.

_____ _____

Employee Waiver Date