Universal Medical Record

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Direct Deposit Authorization Form

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| **AUTHORIZATION AGREEMENT** | | | | |
| **COMPANY NAME: Universal Medical Record** | | **DATE:** | | |
| **EMPLOYEE NAME:** | | **EMPLOYEE ID:** | | |
| **EMPLOYEE EMAIL ADDRESS:** | | | | |
| **ACCOUNT INFORMATION** | | | | |
| **Name of Financial Institution:** | | | | |
| **Routing Number:** |  | % | or | $ |
| **Account Number** |  | Checking | or | Savings |
| **SECOND ACCOUNT INFORMATION** | | | | |
| **Name of Financial**  **Institution:** | | | | |
| **Routing Number:** |  | % | or | $ |
| **Account Number** |  | Checking | or | Savings |
| **PLEASE ATTACH A MANDATORY VOIDED CHECK** | | | | |
| **I understand that Universal Medical Record provides (UMR) payroll service for my Employer. I hereby authorize and direct UMR to make deposits into my account(s) which is (are) designated on this authorization form. Furthermore, if UMR makes a deposit into my account in error or in an incorrect amount, I agree to return the funds to UMR and/or I authorize UMR to withdraw the funds from my account as may be appropriate. This authorization shall remain in effect until it is revoked by me by written notice of revocation received by UMR. You must specify by circling Checking or Savings Account. Any account information that is submitted incorrectly may result in an incurred banking fee of no less than $50** | | | | |
| **Employee Name (Print):** | | | | |
| **Employee Signature:** | | | | |

UMR Form 05292020 ver 1.01