

Authorization Agreement

I hereby authorize Griswold Home Care to initiate automatic deposits to my account at the financial institution named below. I also authorize Griswold Home Care to make withdrawals from this account if a credit entry is made in error.

Further, I agree not to hold Griswold Home Care 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 Griswold Home Care 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

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____

Account Type: ☐ Checking | ☐ Savings

For Direct Deposit and Automatic Payment through Checking

Use information found on your checks

SAMPLE CHECK 0101

DATE: _____

PAY TO THE ORDER OF _____ \$ _____

DOLLARS

WELLS FARGO

MEMO _____

⑆ 23456789⑆ ⑆ 23456789⑆ ⑆ ⑆ ⑆

Routing Number
Account Number
Check Number

Note: You can also find your Account Number on your statement or on the account documents provided at account opening.

Signature

Authorized Name (printed): _____

Date: _____

Authorized Signature (Primary): _____

Authorized Signature (Joint): _____

Date: _____

Please attach a voided check or deposit slip and return this form to Griswold Home Care via email at office@ghcplano.com or by fax to 469-277-3820