Direct Deposit Request Form

_____

Company Name:

_____

Contact Name(Owner, Office Manager, or Accounts Payable etc):

_____

Company Office Address: City: State: Zip:

(____)_____(____)_____

Company Telephone Number Company Fax Number

I, hereby authorize **COMPLETE CARE HOME WARRANTY 'CCHW'** to initiate automatic deposits to my account, to the financial institution name listed below. In the event of a direct deposit payment being unsuccessful, **'CCHW'** will make every effort to release payment expeditiously.

Furthermore, I agree not to hold **'CCHW'** responsible for any delay or loss of funds due to: incorrect or incomplete information; failure to invoice within 30 days of job completion; and/or invoicing for work done without prior approval.

This agreement will remain in effect until **'CCHW'** receives written notice of cancellation from me or my financial institution, OR until I submit a new direct deposit form to the Accounts Payable department.

Bank Name:_____

Routing Number:_____

Account Number:_____

_____

Signature and Date