MENTAL HEALTH ASSOCIATION, INC.

Direct Deposit Authorization

Name (please print) | Date | Company Name

Mental Health Association

ALL ACCOUNTS LISTED MUST BE IN YOUR NAME.
PLEASE ATTACH A CANCELLED OR VOIDED CHECK FOR EACH ACCOUNT LISTED.
PLEASE BE AWARE IT MAY TAKE 2-3 WEEKS FOR DIRECT DEPOSITS TO BECOME EFFECTIVE.
IF MAKING CHANGES TO YOUR DIRECT DEPOSIT PLEASE LET US KNOW IF AN ACCOUNT IS CLOSED.

Bank Name	Bank Routing/ABA No.		Account Type	Deposit Amount
			☐ Checking ☐ Savings	
			☐ Checking ☐ Savings	
			☐ Checking ☐ Savings	

Your Financial Institution will be able to provide you with the proper Bank Routing/ABA number.

I authorize Checkwriters and the Financial Institutions listed below, to Deposit my pay automatically to the accounts listed above. I agree to indemnify and hold each participating Bank, NACHA and Checkwriters harmless from any claim related to the operation of this plan arising form any act or omission of my Company or Checkwriters. These claims include any alleged loss as a result of non-credit of any deposit, and any claim which may be made as a result of the rejection of any of my debits because of insufficient funds arising from failure to credit deposits to my account.

SIGNATURE