

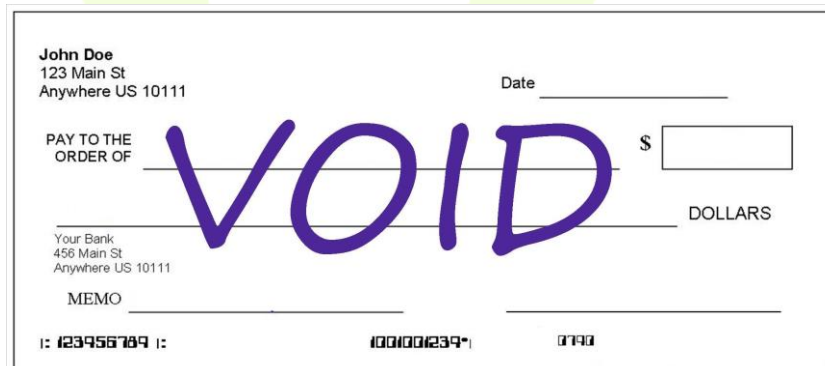
**DIRECT DEPOSIT
PAYMENT AUTHORIZATION FORM**
****PLEASE WRITE LEGIBLY****

Employer Name: _____

Payee Name: _____

Payee Email address for voucher confirmation: _____

ATTACH A VOIDED CHECK COPY ON THE PICTURE OF THE VOIDED CHECK BELOW. If no check copy can be provided, please obtain an account verification letter from your bank. Forms without a check or verification letter will not be processed



Account Type (mark one): CHECKING SAVINGS

Account Class (mark one): BUSINESS INDIVIDUAL/PERSONAL

If your information is different than listed on the check please provide your:

Address: _____

Phone Number: _____

I authorize HPC and the financial institution named above to remit my payment via ACH. This also includes my authorization to reverse any entries that were made in error. This authorization will remain in effect until the company receives written notice from me.

Payee Signature: _____ Effective Date: _____

Return your completed form by mail to:

The Health Planning Council of Southwest Florida
8961 Daniels Center Drive, Suite 401
Fort Myers, FL 33912