



AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

COMPANY: ALEGO HEALTH

EMPLOYEE NAME (print)

SOCIAL SECURITY NO.

- I hereby authorize Alego Health (The Company), to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account(s) listed below.
- I also understand that my bank has up to 48 hours from the date of processing to make my funds available.
- I also understand that there may be a 1-2 week delay in processing depending on when my authorization agreement is received. I may receive two checks before my direct deposit occurs.
- You may put 100% of your pay into one account or split your deposit between 2 accounts.

Account #1

_____	_____	_____	_____
Bank Transit/ABA#	Account Number	Checking/Savings	Dollar Amount/Percentage

Account #2

_____	_____	_____	_____
Bank Transit/ABA#	Account Number	Checking/Savings	Dollar Amount/Percentage

- The authority is to remain in full force until which time the Company has received written notification from me of its termination in such time as to afford the Company and the financial institution a reasonable opportunity to act on it.

Date _____

Signature _____

If you want a percentage split, please note the example:

Account #1- 75%

Account #2- 25% (balance of net)

(For Checking Account attach voided Check here- no deposit slip unless pre-printed accepted)
 (For Savings Account please provide your bank name and routing number)

** FOR ALL OUT OF STATE EMPLOYEES, BE SURE TO GIVE US YOUR BANK NAME, ADDRESS AND PHONE NUMBER IN ADDITION TO THE VOIDED CHECK OR SAVINGS ACCOUNT INFO**