Direct Deposit Authorization

Attach a voided check or photocopy of a check for checking account.

DO NOT ATTACH A DEPOSIT SLIP

Please print clearly

Check one of the following	Effective Date
[ ] Start	[ ] As Soon As Possible
[ ] Stop	[ ] Date ___ /___ / ______
[ ] Change	

Name (Last, First, MI)

SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL AND/OR EXPENSE REIMBURSEMENT CHECK WILL GO TO THIS FINANCIAL INSTITUTION

Financial Institution Name (Bank, Credit Union, etc.)

Enter the following information from the bottom of your check:

ABA Bank Routing Number (must be 9 numbers)

Account Number

Type of Account

Checking [ ] Savings [ ]

I authorize MID AMERICA HEALTH, INC. and/or MID AMERICA PROFESSIONAL GROUP, PC to direct deposit funds to my account in the financial institution listed above and authorize the financial institution listed above to accept these funds. I understand that the authorization may be rejected or discontinued at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, I understand funds payable to me will be returned to MAH/MAPG for distribution. This authorization will cover both payroll and expense reimbursements. If funds to which I am not entitled are deposited in my account, I authorize MAH/MAPG to direct the financial institution to return said funds to MAH/MAPG by any such method, and I authorize the financial institution to withdraw said funds from my account.

Date (MM/DD/YYYY)	Employee Signature	Daytime Phone Number

Home Address	Street	City	State	Zip