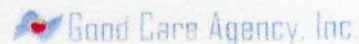


DIRECT DEPOSIT AUTHORIZATION



If you have any questions, please contact contact Good Care Agency, Inc. at (718) 635-3535 or visit our website at www.goodcareagency.com

EMPLOYEE INFORMATION		
First Name	Home Phone () -	
Last Name	Work Phone () -	
Social Security No.	Email Address	
Street Address		Apt No.
City	State	ZIP

DIRECT DEPOSIT AUTHORIZATION	SELECTIONS BELOW	
ALL Bank Information Below is REQUIRED		
Bank Nine Digit Routing Number (Include ALL Zeros):		
Bank Account Number: _____ (Include All Zeros)	Please Select One Below: <input type="checkbox"/> Begin Direct Deposit <input type="checkbox"/> Change Bank Information <input type="checkbox"/> Cancel Direct Deposit	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank Name: _____		

EMPLOYEE AUTHORIZATION AND ACKNOWLEDGEMENT

- My financial institution can receive transactions via electronic transfer and the bank information provided will serve for this purpose.
- I permit Good Care Agency, Inc. to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and/or debit the same to such account.
- Direct deposit of my reimbursements shall commence within 4 (four) weeks of receipt of this form.
- My direct deposit may be terminated by: a written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, or cancellation of direct deposit by my employer.

I hereby understand the information on this form and authorize Good Care Agency, Inc. to complete my request.

Signature	Date / /
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VOID CHECK

We MUST have a copy of a voided check in order to process your request. PLEASE ATTACH VOIDED CHECK HERE: