CalCPA Health

Direct Deposit Authorization Form

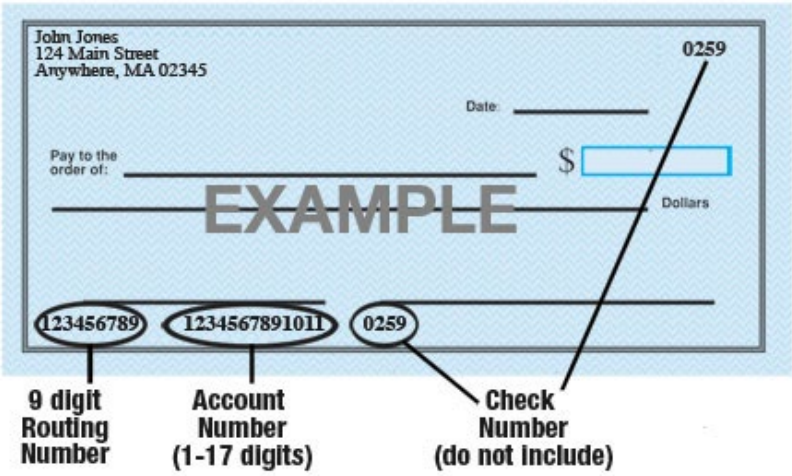
Please type or print and complete ALL the information below.

Company Name: _____

Address: _____

City, State, Zip: _____

Phone and email: _____



Please attach a copy of a voided check and/or bank confirmation letter with account information.

Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Type of Account: Checking ☐ Savings ☐ (Check One)

Group Insurance Trust of the California Society of Certified Public Accountants dba CalCPA Health is hereby authorized to directly deposit to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

Please note:

It may take up to two (4) business days for funds to settle in the recipient's account.

Please return completed form to: John Bailey at john.bailey@calcpahealth.com