Direct Deposit Authorization Agreement

Company Name	Employee #
I hereby authorize	
employer, subject to the success my employer does not make ava	earnings into my account may be an advance of funds on behalf of my sful collection of these funds by Pay USA, Inc. If, within 30 days of the deposit ilable these funds, which were advanced for the deposit, I authorize Pay USA, over said advance (n its entirety or in part) and agree to hold them harmless of the deposit.
New Payroll Deposit	Change Deposit Information
Direct Deposit (Net Pay)	
Depository Name:	
City:	State: Zip:
Bank Transit #	Account #
Checking Sa	avings (please check one)
Direct Deposit (Additi	onal Account)
Depository Name:	
City:	State: Zip:
Bank Transit #	Account #
Checking Sa	avings (please check one) Flat Dollar Amount:
	<u> </u>
Name (print):	SSN:
Signature:	Date:
Co-signature (if joint accou	int):
	Date:
ATTACH a voided blank ched	ck or savings account deposit slip to validate account information (DO
NOT attach a checking accou	nt deposit slip)
This authority is to remain in fu	ll force and effect until Company has received written notification from me on
its termination in such time and	I in such manner as to afford the Company a reasonable time to act on it.
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