Authorization for ACH Transfer

Please Print or Type

Payee Name
Address
Telephone #

EIN/Tax ID/SS #

Please allow 2-3 weeks for direct deposit to take effect.

Action (Check one): ☐Enroll ☐Change ☐Cancel

1. I hereby authorize Meritain Health, 300 Corporate Parkway, Amherst, NY 14226, hereinafter called COMPANY, to initiate credit entries to my account indicated below and the depository name, hereinafter called DEPOSITORY, to credit the same account.
2. Deposit to the following account:
   Checking Account Savings Account

Depository Bank Name

Bank Routing Number

Account Number

Note: There is no notification of transfer.

4. I agree to allow the COMPANY to stop payment or posting of, reverse, or adjust any entry erroneously credited to my account.
5. This authorization is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and manner as to afford the COMPANY a reasonable opportunity to act on it.

Print Name Title (if applicable) Date

Signature

Mail this form with attached documents to: **MERITAIN HEALTH, ATTN: ACCOUNTS PAYABLE, PO BOX 1652, AMHERST, NY 14226**

Email to: **ACCOUNTSPAYABLE@MERITAIN.COM**

Contact Accounts Payable with any questions regarding ACH at (716) 319-5153

Please Attach Your Voided Check Here
(Scanned images of the check are also acceptable)