

# AUTOMATIC DEPOSIT AUTHORIZATION FORM

*Please type or print clearly, sign in the spaces provided.*

## I. Firm Information

|           |     |  |     |
|-----------|-----|--|-----|
| Firm Name |     | Client Code <i>(six-digit number appearing on invoice)</i> |     |
| Address   |     | Tax Identification Number                                  |     |
| City      |     | State  | Zip |
| Phone     | Fax |  |     |

## II. Firm Contact Information

|              |       |           |
|--------------|-------|-----------|
| Contact Name | Phone | Extension |
| Title        | Fax   |           |

## III. Automatic Deposit Authorization

*Complete this section and attach a blank check marked "VOID" to this form (DEPOSIT SLIPS ARE NOT ACCEPTABLE).*

**Authorization** – As a convenience to our firm, we request and authorize the Group Insurance Trust of the California Society of Certified Public Accountants to charge to our account checks drawn on that account payable to the order of the Group Insurance Trust of the California Society of Certified Public Accountants provided there are sufficient collected funds in said account to pay the same upon presentation. We agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by us. We authorize the Group Insurance Trust of the California Society of Certified Public Accountants to initiate debits (and/or corrections to previous debits) from this account with the financial institution indicated for payment of our Group Insurance Trust of the California Society of Certified Public Accountants premiums. This authority is to remain in effect until revoked by us in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. We further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

**Note:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed monthly. After 12 months, you may re-apply for the monthly checking account deduction option. You may incur a \$25 service charge for any withdrawal not honored.

***Authorized Signature(s) as it appears in the financial institution's records.***

|           |           |
|-----------|-----------|
| Name      | Name      |
| Title     | Title     |
| Signature | Signature |

## IV. Financial Institution Account Information

|                  |        |     |  |
|------------------|--------|-----|--|
| Institution Name | Branch |     |  |
| City             | State  | Zip |  |

**Do Not Write Below This Line**

|                                     |               |                      |  |
|-------------------------------------|---------------|----------------------|--|
| Transit/ABA Number (Routing Number) |               | Account Number       |  |
| Effective Date                      | Date Received | Entered/Processed By |  |

Submit completed form and attachment to:

Banyan Administrators  
Managers for the CalCPA Health Programs  
1215 Manor Drive, Suite 200  
Mechanicsburg, PA 17055  
Fax - (877) 237-4519 Phone - (877) 480-7923  
calcpahealth@calcpahealth.com