Employer | ACH Debit Authorization Form

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS) FOR MONTHLY ADMINISTRATION FEES

Bank Filter Information: **Company Name:** INTEGRAFLEX
Company ID Number: 1-260404651
Description: Admin. Fees

I (we) hereby authorize Integrated Disability Management, Inc. d/b/a/ IntegraFlex hereinafter called COMPANY, to initiate debit entries to my (our) *(select one)*

☐ **Checking Account**

☐ **Savings Account**

indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY INFORMATION

Depository Name | Branch

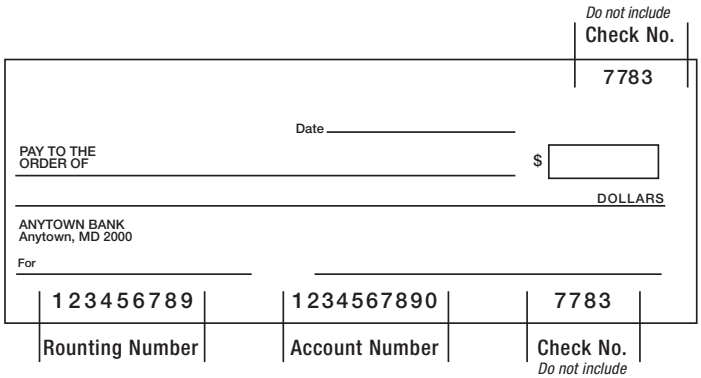
Address | City | State | Zip

Routing Number *(9 Digits)* | Account Number

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s) *(Please Print)*

Signature **Date**



Please attach a **VOIDED CHECK** to this authorization if a checking account will be debited.
The routing and account numbers may be in different places on your check.