

DIRECT DEPOSIT APPLICATION FORM

Direct Care Worker (DCW) Name: _____

Participant ID #: _____ Participant Name: _____

Account Information

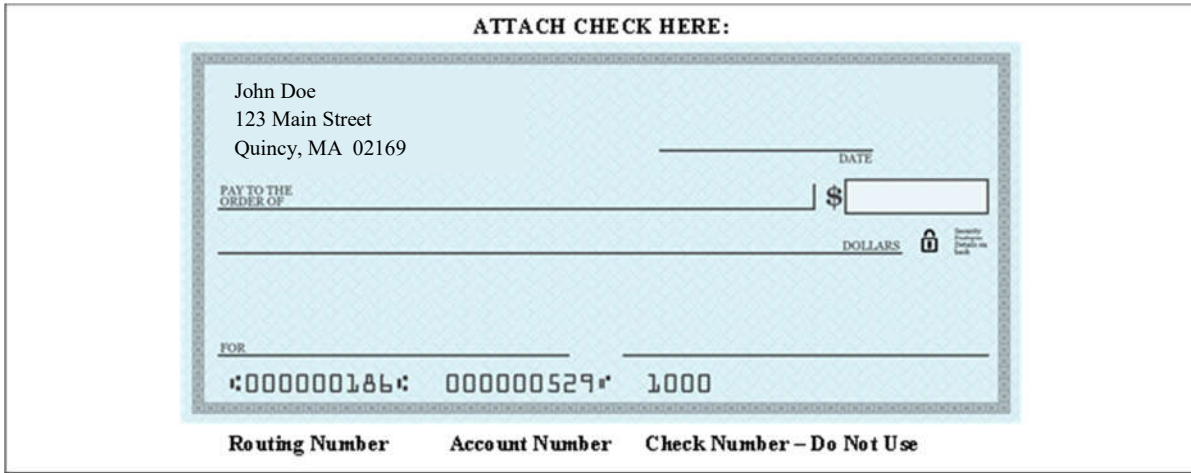
Name on Bank Account: _____
(Direct Deposit Accounts must include the name of the DCW)

Bank Name: _____

Bank Routing #: _____ Bank Account #: _____

This is a Checking Account Savings Account

For a checking account, please attach a voided check or a copy of a check (Starter checks must contain a preprinted DCW name and account number). For a savings account, please attach a document from the bank indicating the DCW's name, the routing number and account number (cannot be handwritten). **Do not attach a deposit slip. We will not process this application without a voided check, a copy of a check, or a document from your bank indicating the routing number and account number.**



I hereby authorize Tempus Unlimited, Inc. (hereinafter "Company") to deposit any amounts owed to me by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize the Bank to accept and to credit any credit entries indicated by the Company to my account. In the event that the Company deposits funds erroneously into my account, I authorize the Company to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until the Company and the Bank have received written notice from me of its termination. The termination can take up to seven (7) business days of receipt of written notice for termination to be effective.

DCW Signature: _____ Date: _____