

ACH DIRECT DEPOSIT ENROLLMENT FORM

Last Name

First Name

Street

Apt #

City

State

Zip

Permanent Phone #

I hereby authorize RTG Medical to deposit amounts owed to me by initiating credit entries to my accounts at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by RTG Medical to my account. In the event that RTG Medical deposits funds erroneously into my account, I authorize RTG Medical to debit my account for an amount not to exceed the original amount of erroneous credit.

This authorization is to remain in full force and effect until RTG Medical and Bank have received written notice from me of its termination in such time and in such manner as to afford RTG Medical and Bank reasonable opportunity to act on it.

ACH Direct Deposit is **only** available in the United States. To enroll, fill out this form and **fax** it to RTG Medical at **1 877.550.6600**. Attach a copy of a voided check (not a deposit slip).

If depositing into a savings account, ask your bank to give you the Routing/Transit Number for your account.

USE ONLY IF A CHECK IS NOT AVAILABLE

Bank Name: _____

Address: _____

City: _____ State: _____

Phone: _____ Zip: _____

9 Digit Routing No. _____

Account No. _____

Account Type: ☐ Checking ☐ Savings

Signature

Date

Printed Name

Attach Voided Check Here