HEKTOEN INSTITUE, L.L.C. **2240 W. Ogden Ave., Chicago, IL 60612 Phone 312.768.6000 Fax 312.768.6010**

Authorization Agreement for Payroll Deposits

EMPLOYEE NAME: ___________________________________ **SS#:** __________

I hereby authorize Hektoen Institute, L.L.C., to initiate credit entries to my account(s) indicated below and the depository(s) named below, hereinafter called DEPOSITORY, to credit the same such account(s), and in the event a credit is made to my account in error, I authorize Hektoen Institute, L.L.C. to make a correcting entry under the condition that I am notified of said adjustment. **NOTE: YOU MUST ATTACH A VOIDED CHECK OR APPROPRIATE DOCUMENTATION FOR EACH ACCOUNT. SUBMIT FORM 5 BUSINESS DAYS BEFORE PAYDATE.**

DEPOSITORY: ____

BANK NAME

___ Checking
___ Savings ____
____ Other ADDRESS CITY/STATE ZIP

Amount to be Credited: $_____________________

Banking Transit/ABA: ___________________ Acct No. ___________________

DEPOSITORY: ____

BANK NAME

___ Checking
___ Savings ____
____Other ADDRESS CITY/STATE ZIP

Amount to be Credited: $_____________________

Banking Transit/ABA: ___________________ Acct No. ___________________

DEPOSITORY: ____

BANK NAME

___ Checking
___ Savings ____
____ Other ADDRESS CITY/STATE ZIP

Amount to be Credited: $_____________________

Banking Transit/ABA: ___________________ Acct No. ___________________

Signature _______________________________ Date ___________________

TERMINATION OF AGREEMENT

Signature _______________________________ Date __________________

______ I hereby request all direct deposit to stop immediately. Date: __________ (initial). Request form from human resources (HR) to terminate agreement. Complete form and fax form immediately to HR without account information to terminate agreement.