LEGACY HEALTH

Direct Deposit Authorization Form

For Receiving Payments from Legacy Health by Electronic Funds Transfer

COMPANY INFORMATION:

COMPANY NAME:_____ TAX ID NUMBER:_____

CONTACT NAME:_____ TELEPHONE NUMBER: (____) _____

EMAIL ADDRESS FOR REMITTANCE ADVICE:_____

BANK INFORMATION:

DEPOSITORY ("BANK")

NAME:_____ BRANCH:_____

CITY:_____ STATE:_____ ZIP:_____

ACCOUNT TYPE: ☐ Checking ☐ Savings

ACCOUNT NAME:_____

TRANSIT/ABA NO:__ __ __ __ __ __ __ __ __ ACCOUNT NO:_____

OPTIONAL INFORMATION:

ADDENDA (additional information to include with payment): _____

AUTHORIZATION:

By signing below, You certify that You are either: (i) the owner of the bank account identified above ("Account") or (ii) lawfully authorized to execute this document on behalf of the company identified above ("Company"). You authorized Legacy Health System ("Legacy") and its subsidiaries, employees and agents to deposit any payments due to the Company into the Account and to adjust debit entries for any such deposits made in error (provided we will notify Company of such deposits made in error). This authorization remains in effect until Legacy and the Bank have received written notice from You and in such manner as to afford Legacy and the Bank a reasonable opportunity to act on it.

NAME:_____ TITLE:_____
(Please Print)

SIGNED:_____ DATE:_____/_____/_____

Please mail or email completed form to:

AccountsPayable@LHS.org

Legacy Health Accounts Payable
PO Box 2904
Portland, OR 97208-2904