

# AUTOMATIC DEPOSIT AUTHORIZATION FORM

*Please type or print clearly, sign in the spaces provided.*

I. Firm Information			
Firm Name	Location Number <i>(as it appears on your premium statement)</i>		
Address	Tax Identification Number		
City	State	Zip	
Phone	Fax		
II. Firm Contact Information			
Contact Name	Phone	Extension	
Title	Fax		
III. Automatic Deposit Authorization			
<p><i>Complete this section and attach a blank check marked "VOID" to this form (DEPOSIT SLIPS ARE NOT ACCEPTABLE).</i></p> <p><b>Authorization</b> – As a convenience to our firm, we request and authorize the Group Insurance Trust of the California Society of Certified Public Accountants to charge to our account checks drawn on that account payable to the order of the Group Insurance Trust of the California Society of Certified Public Accountants provided there are sufficient collected funds in said account to pay the same upon presentation. We agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by us. We authorize the Group Insurance Trust of the California Society of Certified Public Accountants to initiate debits (and/or corrections to previous debits) from this account with the financial institution indicated for payment of our Group Insurance Trust of the California Society of Certified Public Accountants premiums. This authority is to remain in effect until revoked by us in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. We further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p> <p><b>Note:</b> Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed monthly. After 12 months, you may re-apply for the monthly checking account deduction option. You may incur a \$25 service charge for any withdrawal not honored.</p>			
<b>Authorized Signature(s) as it appears in the financial institution's records.</b>			
Name	Name		
Title	Title		
Signature	Signature		
IV. Financial Institution Account Information			
Institution Name	Branch		
City	State	Zip	
Do Not Write Below This Line			
Transit/ABA Number (Routing Number)	Account Number		
Effective Date	Date Received	Entered/Processed By	

Submit completed form and attachment to:

Banyan Administrators  
 Managers for the CalCPA Health Programs  
 1215 Manor Drive, Suite 200  
 Mechanicsburg, PA 17055  
 Fax - (877) 237-4519 Phone - (877) 480-7923  
 calcpahealth@calcpahealth.com