ASSOCIATED EYE CARE, INC.

DIRECT DEPOSIT FORM

EMPLOYEE NAME: _____

EMPLOYEE SS#: _____

Please attach a void check or a copy of a check for enrollment on the next company payroll. Handwritten routing and account number information will require a pre-note validation period of two weeks.

_____New Request _____Change Request

_____Checking: Please attach a void check or copy of a check

_____ Savings: Bank Routing # _____

Account # _____

I wish to deposit:

_____ Entire Pay _____ % of Net Pay $_____ Specific Amt.

_____New Request _____Change Request

_____Checking: Please attach a void check or copy of a check

_____ Savings: Bank Routing # _____

Account # _____

I wish to deposit:

_____ Entire Pay _____ % of Net Pay $_____ Specific Amt.

Employee Signature: _____ Date: _____

Payroll Signature: _____ Date: _____