EMPIRE HEALTHCARE
INDEPENDENT PHYSICIANS ASSOCIATION

Empire Healthcare
C/O All Care To You
PO Box 4367
Orange CA 92863

AUTHORIZATION FOR ACH DEPOSIT OF VENDOR PAYMENT

Payee/Vendor Name _____

Address _____

City, State Zip _____

Telephone _____

Contact Name _____

Contact e-mail _____
(for ACH remittance notification)

Complete this section for **new enrollments** or for **financial institution or account changes.**

Select one: ____New Enrollment ____Financial Institution or Account Change

Bank Name _____

Branch (if applicable) _____

City, State Zip _____

Transit/Routing Number ____ ____ ____ ____ ____ ____ ____ ____ ____

Bank Account Number _____

Account Type (check one) ____Checking Account ____Savings Account

I, the undersigned, authorize Empire Healthcare to deposit payments directly to the account indicated above and to correct any errors which may occur from the transactions. I also authorize the financial institution named above to post these transactions to that account. This authorization will remain in force until Empire Healthcare receives written notice of cancellation from me. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Signature _____ Date_____

Name (printed)_____ Title_____

Complete this section to **CANCEL** your ACH electronic deposit authorization.

I, the undersigned, hereby cancel the authorization for Empire Healthcare to originate ACH electronic deposit entries into my checking/savings account. This cancellation is effective as soon as Empire Healthcare has reasonable time to act upon it.

Signature _____ Date _____

Name (printed) _____ Title _____

Mail the completed form to the address above, fax to (949)396-2614 or email to MikeSayed@AllCareToYou.com

For EHI Use Only

Vendor Number _____ Date Received _____