Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSIT

Point of Contact with Trillium Health Resources: _____

I hereby authorize Trillium Health Resources to initiate credit entries to my (Please select one of three options)

☐ Checking ☐ Savings account indicated below and the bank named below, hereinafter called **DEPOSITORY,** to credit the same to such account.

☐ I decline Automatic Deposit services and understand that I will receive payment in the form of a check. I understand that checks take up to 5-10 business days for processing and delivery.

Depository Bank Name _____

City _____ State _____

Routing No._____ Account No. _____

This authority is to remain in full force and effect until Trillium Health Resources has confirmed receipt of written notification of termination.

Vendor/Provider Name _____

Contact Name: _____

Full Mailing Address _____

Phone Number: _____ Fax: _____

Date_____ **Signed** _____

Email address: _____

Please list any additional contacts requiring receipt of email for deposit notifications;

Name: _____ Email: _____

Name: _____ Email: _____

Name: _____ Email: _____

REQUIRED - Please attach the following to your completed form;

- Voided check or letter from the depository bank for authorization purposes
- Current W9 Form with signature and date

Unless instructed otherwise, return completed form along with required documentation to:

Email: FinanceForms@TrilliumNC.org
Fax: 252.215.6876 or
Mail: 144 Community College Road, Ahoskie NC 27910

If forms are incomplete they will be returned for corrections and this delays processing

For internal use only:

Name of requestor_____ **Department:** _____