



Authorization Agreement for Direct Deposit

- ▶ **Important note:** All fields must be filled in completely before submitting.
- ▶ Email to AsperaPay at AsperaPay@input1.com

Agency/Principal Information

Date: _____ Agency Code #: _____ Agency Principal Email: _____

Agency Name: _____

Agency Address: _____

City: _____ State: _____ Zip Code: _____

Bank Information

Bank Name: _____

Bank Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Transit Number: _____

Bank Account Name: _____

I authorize AsperaPay to deposit proceeds with the financial institution I provided above. The financial institution is authorized to credit those funds to the account provided. This authorization will remain in effect until I have given 30 days written notice of its termination or until AsperaPay or my financial institution has given me 10 days notice that this direct deposit has been terminated. I understand that I must give advance notice to allow reasonable time for my instructions to be executed. Should an incorrect amount should be entered into my account, I authorize my financial institution to make the appropriate adjustment.

Print Agency Principal Name

Date

Agency Principal Signature