Authorization for Automatic Payroll Deposits

I, _____, hereby authorize and instruct Dental Employer Services, Inc. to deposit the amount of each of my payroll payments directly into my checking and/or savings account indicated below in the amounts indicated below in the Deposit Instructions. I grant Dental Employer Services, Inc. the right to correct any Automatic Payroll Deposits resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

I further hereby authorize and instruct my bank to accept such automatic deposits to and withdrawals from my account or accounts by Dental Employer Services, Inc. and to cause my account or accounts to be automatically credited or debited (as the case may be) in the amount of such deposits or withdrawals by Dental Employer Services, Inc. without any responsibility for correctness of any such deposit or withdrawal. Further, I will not hold Dental Employer Services, Inc. responsible for any fee that I may incur for any reason related to the Automatic Payroll Deposits and will hold harmless Dental Employer Services, Inc. in the event that my paycheck is late, misrouted, returned to the bank, or any other unforeseen cause or bank error and any and all results from that bank error.

Deposit Instructions

_____ Please deposit the full amount of each of my payroll payments to my CHECKING account.
Initial

_____ _____
Routing Number Account Number

_____ Please deposit the full amount of each of my payroll payments to my SAVINGS account.
Initial

_____ _____
Routing Number Account Number

_____ Please deposit the full amount, indicated below, of each of my payroll payments to my
Initial SAVINGS account and the remainder of each payroll payment to my CHECKING account.

Savings Acct: % _____ _____ _____
Whole % Routing Number Account Number

Checking Acct: % _____ _____ _____
Whole % Routing Number Account Number

I understand that I can cancel this authorization at any time. To cancel, I must give written notice to both Dental Employer Services, Inc. and my bank. Please allow 2-3 weeks for these transactions to appear or be discontinued from your account(s).

I understand that all automatic deposits and credits to or withdrawals and debits from my account or accounts under this authorization will be subject to all rules, regulations, agreements and disclosure statements of Dental Employer Services, Inc. and the Bank governing accounts and preauthorized transfers to and from accounts.

By signing, I acknowledge receiving a completed copy of this authorization on the date I signed below and agree to every term and condition of this Authorization.

E-MAIL ADDRESS: _____

Printed Name Signature Social Security Number Date

PLEASE BE ADVISED A VOIDED CHECK IS REQUIRED FOR PROCESSING. FOR SAVINGS PLEASE ENTER YOUR ACCOUNT NUMBER AND A CORRECT ROUTING NUMBER THAT YOUR BANK WILL SUPPLY. DEPOSIT SLIPS DO NOT HAVE THE CORRECT INFORMATION TO PROCESS YOUR REQUEST. DEPOSIT VOUCHERS WILL BE E-MAILED. PLEASE PROVIDE A VALID E-MAIL ADDRESS.