



# AUTHORIZATION FOR DIRECT DEPOSIT FOR SHORT-TERM DISABILITY

I authorize AultCare to deposit my pay automatically to the account indicated below, and if necessary, to adjust or reverse a deposit for any payroll entry made to my account in error.

Name on Bank Account		
Bank Name		
Bank Account Number	<input type="checkbox"/> Checking Account	<input type="checkbox"/> Savings Account
Bank Routing Number		

Employee or Company Signature \_\_\_\_\_ Date \_\_\_\_\_

PO Box 6910 Canton, OH 44706 | Fax: 330-470-4757 | 330-363-6360 | 1-800-344-8858 | TTY: 711  
[www.ancillaryclaimsservices@aultcare.com](mailto:www.ancillaryclaimsservices@aultcare.com)