Direct Deposit Enrollment

Name: _____

Bank Name: _____

Account Number: _____

Bank Routing Number: _____

Checking or Savings: _____

Business or Personal Account: _____

Remittance Email: _____

Authorization Agreement: I hereby authorize Health Management Associates (HMA) to deposit invoice payments directly into the account(s) named above. This authority will remain in force until I have given written notice that I am terminating it, or until HMA has notified me that this deposit service has been discontinued. I understand that I must give advance notice to allow reasonable time for my instructions to be executed. If an incorrect deposit should be made into my account(s), I authorize my bank(s) and HMA to make the appropriate adjustment(s) after notifying me first.

_____ _____

Signature Date

120 N. WASHINGTON SQUARE
SUITE 705
LANSING, MI 48933
TELEPHONE: 517.482.9236
FAX: 517.482.0920
WWW.HEALTHMANAGEMENT.COM