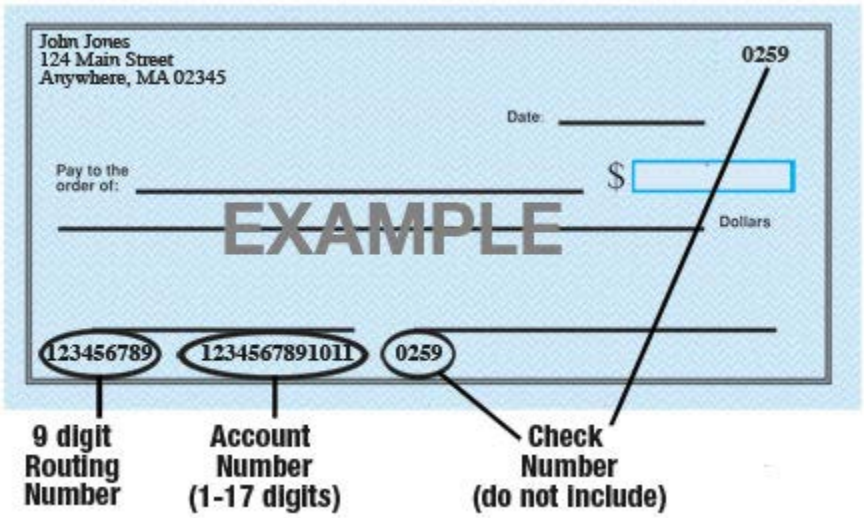
VAFR Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Type of Account: ☐ Checking ☐ Savings (Check One)

RCG is hereby authorized to directly deposit my reimbursement to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Signature: _____

Date: _____

Please attach a voided check, if possible.