Electronic Deposit Authorization

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Provider Information

Provider Name______________________________ **Provider ID#** ________________

Address ____

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Phone ________________ **Fax** ________________ **Email** ____________________

Banking Information

Name of Financial Institution (The "Bank") ____________________________

Branch Address:____

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Electronic Deposit Authorization And Agreement

PLEASE ATTACH A VOID CHEQUE

I, the undersigned, authorize Quikcard Solutions Inc. ("Quikcard") to credit the account identified on the attached void cheque (the "Account") for payments administered by Quikcard in respect of treatment claims.
Each payment shall be the same as if I had personally received a cheque from Quikcard and deposited it to the Account.
I will notify Quikcard promptly in writing if I move the Account from my Bank or branch to another, or if there is any other change in the Account.
This authorization may be cancelled by either me or Quikcard.
Any delivery of this authorization to Quikcard constitutes delivery by me to my Bank.
I am the person who is authorized to sign on the Account.
I have kept a copy of this authorization form.

I authorize Quikcard Solutions Inc. to credit my account for payments administered by Quikcard in respect of treatment claims.

I have attached a void **cheque**

____
Provider's Signature

____
Date

Consult Quikcard's privacy policy at www.quikcard.com/privacy-policy/ or contact Quikcard by phone or mail.