Employer Name	Employee Name

Authorization for Direct Deposit from David K. Young Consulting, LLC			
Please provide the account information to which you would like your claim reimbursement to be deposited.			
Bank or Credit Union Name	City	State	Zip
Name on the Account	Routing Number	Account Number	
Employer			

This authority is to remain in full force and effective until company has received notification of its termination. This authorization is to allow DKY to deposit funds into the above listed account for Medical and/or Dependent Care reimbursement.

Signature _____ Date _____

ATTACH VOIDED CHECK