



**CHECKING ACCOUNT INQUIRY**

*Please note: All payrolls will be delivered COD "SECURED FUNDS" until a satisfactory NOTARIZED verification is received directly from the Client's bank.*

**MUST BE COMPLETED & NOTARIZED BY CLIENT'S BANK & RETURNED TO CONVERGENCE BY BANK - (SEE BELOW)**

Bank Name: \_\_\_\_\_

Address: \_\_\_\_\_

Account Name: \_\_\_\_\_ Account #: \_\_\_\_\_

Date account opened: \_\_\_\_\_ Average Daily Balance: \_\_\_\_\_

# of NSF since account opened: \_\_\_\_\_ # OF NSF'S Last 12 months: \_\_\_\_\_

Signature of Bank Representative: X \_\_\_\_\_

Print Rep Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Stamp:

**MUST BE COMPLETED BY CLIENT**

Client Name: \_\_\_\_\_

Client FEIN or Owner's SSN#: \_\_\_\_\_

Name of Bank: \_\_\_\_\_

I authorize the release of information regarding the above listed accounts to Convergence Employee Leasing, Inc. for the purposes of credit investigation for business purposes.

Signature (Signatory on above Account): X \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Return to via email or fax to:  
KBOGGAN@CONVERGENCEPEO.COM  
Convergence Employee Leasing, Inc  
9393 Mill Springs Drive  
Jacksonville, FL 32257  
(904) 731-9014/ F (904)-731-0059

**AUTHORIZATION TO HONOR ITEMS DEBITED BY CONVERGENCE  
EMPLOYEE LEASING, INC**

This form must be filled out in its entirety if client is to pay their invoice via ACH debit

**Name of Depositor as shown on Bank Records:** \_\_\_\_\_

**Account Number:** \_\_\_\_\_ **Routing Number:** \_\_\_\_\_

**Bank Name:** \_\_\_\_\_

**Bank Address:** \_\_\_\_\_

**Bank Contact:** \_\_\_\_\_ **Bank Phone Number:** \_\_\_\_\_

**Bank Fax Number:** \_\_\_\_\_

I hereby authorize Convergence Employee Leasing, Inc to debit my account each week to pay for my employee leasing services. No debit shall exceed the amount shown on the weekly invoice that details our weekly payroll, FICA taxes, FUTA taxes, SUI taxes, Workers' Compensation and Management Fee. Additional debits may include health care, dental or other benefits (401K, etc).

Any Debit that is returned for any reason will require payment in the form of a CASHIERS CHECK for future payrolls.

\_\_\_\_\_  
Client Company Name Date

\_\_\_\_\_  
Client Company Address

\_\_\_\_\_  
Signature of Client Representative Title

**ATTACH VOIDED CHECK**



## Check Writer Form

This form must be filled out in its entirety if client is to pay their invoice with company check.

Name of Company: \_\_\_\_\_

Name of Check Writer: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Driver's License No: \_\_\_\_\_ State: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

**Please attach a copy of the Drivers License**

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