



MARYLAND

USA

Commercial Driver's License

CDL



08006F45C

Customer identifier

L-250-585-609-131

Family name

LAWSON

Given names

MARK MONTEZ

Address

**1142 CANVASBACK LN
DENTON MD 21629**

Date of birth

02/19/1966

Sex

M

Height

5'-08"

Weight

215

Date of exp

02/19/2022

Restrictions

Classifications

A

Endorsements

N

Date of issue

02/17/2017

Mark Montez

Form MCSA-5876

Public Burden Statement

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U.S. Department of Transportation
Federal Motor Carrier
Safety Administration**Medical Examiner's Certificate**
(for Commercial Driver Medical Certification)

I certify that I have examined **Last Name: Lawson** **First Name: Mark** in accordance with (please check only one):
☒ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) OR
☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply):
☐ Wearing corrective lenses ☐ Accompanied by a _____ waiver/exemption
☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate
☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
☐ Qualified by operation of 49 CFR 391.64 (Federal)
☐ Grandfathered from State requirements (State)

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature**Medical Examiner's Name (please print or type)****Medical Examiner's State License, Certificate, or Registration Number****Driver's Signature****Driver's Address****Street Address:****Medical Examiner's Telephone Number****Date Certificate Signed**☒ MD ☐ Physician Assistant ☐ Advanced Practice Nurse
☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) _____**Issuing State****National Registry Number****Driver's License Number****Issuing State/Province****State/Province****Zip Code****CDL/CDL Applicant/Holder**☒ Yes ☐ No

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

DISCLOSURE AND RELEASE FORM

SERVICES TO BE PERFORMED

This section should be completed by the Employer

Please indicate below which background checks you wish to have Foley Carrier Services LLC. perform:

<input checked="" type="checkbox"/> Safety Performance History Inquiry (Included)	<input checked="" type="checkbox"/> Criminal Report (Call for pricing)
<input type="checkbox"/> DQF Annual Motor Vehicle Report (Included)	<input type="checkbox"/> National Criminal & Sex Offender Registry Report (Call for pricing)
<input checked="" type="checkbox"/> Drug & Alcohol Inquiry Only (Call for pricing)	<input checked="" type="checkbox"/> Social Security Number to confirm SSN & provides previous addresses (Call for pricing)
<input type="checkbox"/> References (Call for pricing)	<input type="checkbox"/> Education Verification (Call for pricing)
<input type="checkbox"/> Worker's Compensation Claim Report (Call for pricing)	<input type="checkbox"/> Motor Vehicle Report ONLY (Call for pricing)

The receipt of certain background information on an individual involves specific duties and obligations under the Fair Credit Reporting Act. The individual about whom background information is being requested MUST sign this Disclosure and Release.

Any person who knowingly and willfully obtains a consumer report under false pretenses, or for reasons other than employment purposes, may face criminal prosecution.

 OWNER
Employer Authorization (Signature) Title
Roy Salmon Trucking
Company Name Client Code
7/21/17
Date

APPLICANT AUTHORIZATION

This section should be complete by the Applicant

Applicant Profile			
Applicant Name:	Mark Lawson	Social Security Number:	219-84-0620
Date of Application:	7/20/17	Driver's License Number:	L-2505-85-604131
License Expiration Date:	2/19/2022	Date of Birth:	2/19/66
Address 1:	1142 CANVASBACK Ln.	Address 2:	
City:	Denton	State:	WV
Zip:	26224	Telephone:	443-681-0639

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED BY FOLEY CARRIER SERVICES LLC. WITH REGARD TO THIS INQUIRY TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I authorize Foley Carrier Services LLC. and their agents to conduct the background investigations indicated above, in conjunction with my current or prospective employer's service contract with Foley Carrier Services, LLC. I understand that these background checks may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, alcohol and controlled substances testing history, etc. I further understand that such reports may contain public record information concerning my driving record, worker's compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records. Information may also be obtained from Foley Carrier Services LLC and their agents concerning previous driving record requests made by others from such state agencies, and state provided driving records. All information obtained will be provided to my current or prospective employer and used for employment purposes only.

This authorization shall remain on file and shall serve as ongoing authorization for the above named employer to procure motor vehicle reports at any time during my employment (or contract) period.

 SIGN HERE
Applicant Authorization (Signature) Date
7/20/17

APPLICATION FOR EMPLOYMENT

GREEN/FORM NO.

DQF
1

Have all driver-applicants complete this form before driving a commercial motor vehicle.

In compliance with Federal and State equal opportunity employment laws, qualified applicants are considered for all positions without regard to race, religion, color, gender, national origin, age, marital status, or non-job related disability. Please complete both sides of this application thoroughly. Attach additional sheets if more room is required for details.

To be completed by Employer:

Motor Carrier:

Address:

To be completed by Applicant:

Applicant's Name:	Date of Application: 7/20/17
Current Address: 1142 Camuashack Ln Denton, MD 21629	Social Security No.: 219 94 0520
Length of time at this address:	Date of Birth: 2-19-66
	Telephone No.: 443-681-0639

PREVIOUS ADDRESSES FOR LAST THREE YEARS (MOST RECENT FIRST)

Street	City	State/Zip	How long	Additional Information Attached
9/18				<input type="checkbox"/>

LIST ALL UNEXPIRED LICENSES AND/OR PERMITS

State	Number	Expiration Date	Additional Information Attached
Maryland	L-250-585-609-131	2/19/2022	<input type="checkbox"/>

LIST THE NATURE AND EXTENT OF YOUR EXPERIENCE OPERATING DIFFERENT TYPES OF MOTOR VEHICLES (E.G. BUSES, TRUCKS & TRAILERS)

Type	Experience in Years and / or Miles Driven	Additional Information Attached
Tractor/Trailer	1988 to 2017	<input type="checkbox"/>

LIST ALL MOTOR VEHICLE ACCIDENTS IN WHICH YOU WERE INVOLVED DURING THE LAST THREE YEARS

DATE	CITY/STATE	NATURE OF ACCIDENT	FATALITIES	INJURIES
		none		

☐ Check here to certify that you have had no accidents in the last three years
LIST ALL VIOLATIONS (OTHER THAN PARKING) FOR WHICH YOU WERE CONVICTED OR FORFEITED BOND / COLLATERAL DURING THE LAST THREE YEARS

DATE	CITY/STATE	CHARGE	PENALTY
		none	

☐ Check here to certify that no convictions or bond forfeitures have occurred
DQF 1 - APPLICATION FOR EMPLOYMENTRetain for 3 years
after ceasing duties

APPLICATION FOR EMPLOYMENT

PLEASE DETAIL THE FACTS AND CIRCUMSTANCES OF ANY DENIAL, REVOCATION, OR SUSPENSION OF ANY LICENSE, PERMIT, OR PRIVILEGE TO OPERATE A MOTOR VEHICLE:

2009 9 days child support

☐ Check here to certify that no such denial, revocation or suspension has occurred

EMPLOYMENT HISTORY

Please complete all information regarding prior employers during the last three years. If you are applying to operate a Commercial Motor Vehicle (GVWR of 10,001 lbs. or more, ability to transport 8 or more people, or any vehicle requiring placarding for hazardous materials), please include complete information regarding prior employers for the last 10 years for whom you operated such vehicles. Please start with your most recent prior employer (Use additional sheets if necessary).

Employer Name: <u>NorthEast Expedited Express</u>	Employed From: <u>8/1/15</u> To: <u>6/1/17</u>
Address: <u>Carlisle, PA 0410</u>	Position: <u>Truck Driver</u>
Contact: <u>Larry Johnson</u> Phone: <u>410-845</u>	Salary: <u>\$1000.00 wk</u>
Reason for Leaving: <u>owner would not repair Truck</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name: <u>Quality Transport</u>	Employed From: <u>1/1/13</u> To: <u>8/1/15</u>
Address: <u>Denton, WY 7629</u>	Position: <u>Truck Driver</u>
Contact: <u>T. Robinson</u> Phone: <u>410-439</u>	Salary: <u>\$800.00 wk</u>
Reason for Leaving: <u>work slow</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name: <u>Triple J Trucking</u>	Employed From: <u>2/1/07</u> To: <u>1/1/13</u>
Address: <u>Baltimore, MD 8643</u>	Position: <u>Truck Driver</u>
Contact: <u>Greg</u> Phone: <u>443-786</u>	Salary: <u>27 per cent</u>
Reason for Leaving: <u>owner of Dick family died</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

OFFICE USE ONLY

<input type="checkbox"/> Applicant Hired	Date:	Start Date:	Authorized by:
<input type="checkbox"/> Rejected for reasons of:			
<input type="checkbox"/> Date of Termination of Employment:	Authorized by:		
<input type="checkbox"/> Dismissed	<input type="checkbox"/> Quit	<input type="checkbox"/> Other:	
Reason:			

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

Applicant Signature: [Signature]

SIGN HERE

Date: 7/20/17

RECEIPT OF DRIVER'S RIGHTS

PURPLE/FORM NO.

**SPH
1**

Have each driver-applicant sign this form before you accept his/her employment application.

Employers who are regulated by the Federal Motor Carrier Safety Administration (FMCSA) must expressly notify an applicant, who has been employed by a Department of Transportation-regulated employer during the preceding three years, that the applicant has certain rights regarding the investigative information that will be provided by his/her previous employer(s). After providing the driver-applicant with a written copy of these rights, use this form to obtain his/her signature and retain the top copy of this 2-part form. Give the bottom copy to the applicant. By regulation you must inform the driver of his/her rights **before** accepting the driver's application for employment.

DRIVER REVIEW AND RECEIPT

☐ I acknowledge that Ray Spelman Trucking has provided me with written instructions regarding my rights as defined in **Part 391.23(i)-(j)** of the Federal Motor Carrier Safety Regulations. I have reviewed these materials which include information on the following:

- ☒ **Right to Review Information** – I have the right to review the information provided by my previous DOT-regulated employer(s).
- ☒ **Right to Request Corrections** – I have the right to request corrections to information that my previous DOT-regulated employer(s) provides, which I believe contains errors.
- ☒ **Right to Rebut Information** – I have the right to rebut the information provided by my previous DOT-regulated employer(s).

Mark Lawson
Driver's Full Name

[Signature]
Driver's Signature

SIGN HERE

7/20/17
Date

[Signature]
Supervisor/Authorized Motor Carrier Representative Signature

SIGN HERE

7/24/17
Date

Employer Keeps Original, Provides Scan or Copy to Applicant

SAFETY PERFORMANCE HISTORY INVESTIGATION

GREEN/FORM NO.

**SPH
2/3/R**

Use ONE form to investigate applicant's Safety Performance History (SPH) for EACH employer within the previous three years. Three forms provided, make copies as necessary.

TO BE COMPLETED BY APPLICANT:

As the applicant, my signature authorizes you, as my previous employer, to release the requested information to Foley Carrier Services, LLC., the service vendor used by my prospective employer,

Applicant's Name: MARK JOHNSON Social Security Number: 219-94-0620 Client Code: 24SL

Applicant's Signature: [Signature] Previous Employer: NORTH EAST EXPEDITED EXPRESS

TO BE COMPLETED BY PREVIOUS EMPLOYER:

FMCSA regulations require this SPH investigation. Please complete the requested information, using additional paper if necessary. If you have no information to report, please indicate so in the appropriate section. Email completed information to: BSS@FoleyServices.com or fax to: (860) 913-2452.

Verification of Employment

Applicant was employed with this company from: 3/8/15 to: 6/17/17

Position: COMBINATION DRIVER Position required a Commercial Drivers License? ☒ Yes ☐ No

Accident Information

☒ No accident information to report (as defined by Part 390.5)

Date of accident: City or Town (most near) and State: Number of fatalities: Number of Injuries:

Release of hazardous materials? ☐ Yes ☒ No (Not including fuel spilled from the fuel tanks of vehicles involved in the accident)

Additional information about the accident:

Attach additional sheets if necessary and additional accident information as required pursuant to your internal policies.

Prohibited Drug and Alcohol Testing Information

- ☐ Individual was not in a safety-sensitive position subject to the Part 40 regulations while in our employment
☒ No prohibited drug and/or alcohol conduct to report

If the driver engaged in prohibited drug and/or alcohol conduct, **as defined by Part 40 and/or Part 382 only**, during the previous three years, answer the questions below.

During the previous three years did the driver:

Have an alcohol test result with an alcohol concentration of 0.04 or higher?

☐ Yes ☒ No

Have a verified positive drug test result?

☐ Yes ☒ No

Refuse to be tested (this includes receiving a verified adulterated or substituted drug test result)?

☐ Yes ☒ No

Have a violation of any of the other drug and/or alcohol testing prohibitions?

☐ Yes ☒ No

If **yes** to any of the above, did the driver:

Comply with the recommendations prescribed by a Substance Abuse Professional (SAP) pursuant to Part 40, while in your employment?

☐ Yes ☐ No

Successfully complete the return to duty program while in your employment?

☐ Yes ☐ No

Attach additional documentation, if available, to verify the individual's successful completion of the return to duty process.

Previous Employer Contact Information

Part 391.23 requires a previous employer who is regulated by the Dept. of Transportation to provide a specific contact name when responding to a Safety Performance History Inquiry. The driver may choose to contact you regarding the information you provide.

Previous Employer Contact Name: LARRY JOHNSON

Title: OWNER

Telephone: 410-815-0410

Fax:

Mailing Address:

Signature of Company Official releasing this information: [Signature]

SIGN HERE

Date Released: [Signature]

SAFETY PERFORMANCE HISTORY INVESTIGATION

GREEN/FORM NO.

**SPH
2/3/R**

Use ONE form to investigate applicant's Safety Performance History (SPH) for EACH employer within the previous three years. Three forms provided, make copies as necessary.

TO BE COMPLETED BY APPLICANT:

As the applicant, my signature authorizes you, as my previous employer, to release the requested information to Foley Carrier Services, LLC., the service vendor used by my prospective employer,

Applicant's Name: Mark Lawert Social Security Number: 219 94 06 20 Client Code: _____

Applicant's Signature: _____ Previous Employer: Quantity Transport

TO BE COMPLETED BY PREVIOUS EMPLOYER:

FMCSA regulations require this SPH investigation. Please complete the requested information, using additional paper if necessary. If you have no information to report, please indicate so in the appropriate section. Email completed information to: BSS@FoleyServices.com or fax to: (860) 913-2452.

Verification of Employment

Applicant was employed with this company from: 01/05/2013 to: 8/10/2015

Position: Company Driver Position required a Commercial Drivers License? ☒ Yes ☐ No

Accident Information

☐ No accident information to report (as defined by Part 390.5)

Date of accident: _____ City or Town (most near) and State: _____ Number of fatalities: _____ Number of Injuries: _____

Release of hazardous materials? ☐ Yes ☐ No (Not including fuel spilled from the fuel tanks of vehicles involved in the accident)

Additional information about the accident: _____

Attach additional sheets if necessary and additional accident information as required pursuant to your internal policies.

Prohibited Drug and Alcohol Testing Information

☐ Individual was not in a safety-sensitive position subject to the Part 40 regulations while in our employment

☒ No prohibited drug and/or alcohol conduct to report

If the driver engaged in prohibited drug and/or alcohol conduct, as defined by Part 40 and/or Part 382 only, during the previous three years, answer the questions below.

During the previous three years did the driver:

Have an alcohol test result with an alcohol concentration of 0.04 or higher? ☐ Yes ☒ No

Have a verified positive drug test result? ☐ Yes ☒ No

Refuse to be tested (this includes receiving a verified adulterated or substituted drug test result)? ☐ Yes ☒ No

Have a violation of any of the other drug and/or alcohol testing prohibitions? ☐ Yes ☒ No

If yes to any of the above, did the driver:

Comply with the recommendations prescribed by a Substance Abuse Professional (SAP) pursuant to Part 40, while in your employment? ☐ Yes ☐ No

Successfully complete the return to duty program while in your employment? ☐ Yes ☐ No

Attach additional documentation, if available, to verify the individual's successful completion of the return to duty process.

Previous Employer Contact Information

Part 391.23 requires a previous employer who is regulated by the Dept. of Transportation to provide a specific contact name when responding to a Safety Performance History Inquiry. The driver may choose to contact you regarding the information you provide.

Previous Employer Contact Name: T. Robinson Title: DISPATCH

Telephone: 410-439-7629 Fax: _____

Mailing Address: _____

Signature of Company Official releasing this information: _____ Date Released: 7/24/17

Vehicle Safety Policy

The safety of our employees who operate company provided vehicles is of primary importance to ROY SALMON TRUCKING LLC. As a driver of a fleet vehicle, your attitude, driving habits and road courtesy are a direct reflection on the organization. Therefore all drivers shall support and abide by the rules and procedures set forth in this policy.

ROY SALMON TRUCKING LLC will:

- Provide vehicles which meet all federally mandated safety requirements and maintain those vehicles in a safe operating condition
- Provide a vehicle operator manual to all drivers when they are assigned a company vehicle
- Provide auto insurance for each leased vehicle

THE DRIVER will:

- Always operate the vehicle in a safe manner
- All drivers will be held responsible for all damages done to the trucks and trailers due to the negligence of the driver and damages that is beyond normal wear or tear
- Ensure that all occupants of the vehicle wear safety belts at all times when the vehicle is in use and appropriate attire in all facilities.
- Never operate the vehicle while impaired
- Inspect the vehicle to ensure the lights and signals are working properly and the tires are properly inflated
- Ensure all scheduled maintenance is performed in a timely manner and any repairs which are needed are reported immediately
- Report any accident in which you are involved to the proper authority
- Never allow anyone who is not an employee of the ROY SALMON TRUCKING LLC drive the vehicle

DISTRACTED DRIVING /CELLULAR PHONE USE

ROY SALMON TRUCKING LLC prohibits the use of hand-held cellular phones while operating a ROY SALMON TRUCKING LLC provided vehicle. ROY SALMON TRUCKING LLC also prohibits under all circumstances sending or reading emails, text messages from cellular phones, pagers or other devices. There are many States/Provinces that have banned hand-held cell phones and implemented hands-

free and/or texting laws. If you are cited violating any of these states laws, you will be responsible for the fines incurred.

EMPLOYEE ACKNOWLEDGMENT FORM

Because you are a valued member of our team, ROY SALMON TRUCKING LLC provides you with a company-owned vehicle. This vehicle should be used for business reasons, and you should never allow anyone else to drive the vehicle.

Since we are entrusting you with our vehicle, we ask that you treat it with the same care you would give your own.

I AGREE TO THE FOLLOWING:

- 1) I agree to be held accountable for the repair of any damages that are beyond normal wear and tear.
- 2) I agree to schedule the vehicle for the prescribed regular maintenance services.
- 3) I agree to drive safely, carefully, with common sense, and to obey the rules of the road.
- 4) I agree to not let any other person drive my vehicle at any time.
- 5) I have read and understand the Vehicle Safety Policy.

Print Name MARK LAUROO

Signature 

Date 7/20/17

Employer and/or Third Party		INTERCEPT CORPORATION
Name:		1700 42nd St. S, Suite 2000
Street Address:		Fargo, ND 58103
City, State, Zip:		
Telephone:		
Fax Number:		

**Authorization for Debit and Credit
Electronic Funds Transfers**

I hereby authorize on this _____ day of _____, _____ my employer and/or third party as referred to here within, and their agents including Intercept Corporation (IC), to initiate electronic withdrawals and/or deposits to the bank account shown below. I understand that adjustment and/or reversing entries may be made to this account to insure an accurate and balanced accounting of all transactions. This authorization will remain in effect until;

- a) I notify my Bank and IC in writing to terminate this agreement and give the Bank and IC reasonable time to terminate this agreement,
- b) The Bank, third party/employer, and/or IC have sent me five (5) business days advance written notice of the Bank's and/or IC's termination of this Agreement

I understand that any cancellation in writing will become effective no earlier than five (5) business days after the day the last transaction has cleared and there are no outstanding balances to the account.

I UNDERSTAND THAT INTERCEPT CORPORATION PROVIDES ELECTRONIC FUND TRANSFER SERVICES TO THIRD PARTIES AND/OR MY EMPLOYER. THE FUNDS TO BE TRANSFERRED MUST BE COLLATERALLY FUNDED AND ARE FULLY GUARANTEED BY MY EMPLOYER AND/OR MYSELF. IN THE EVENT THE FUNDING FOR A TRANSFER IS RETURNED FOR ANY REASON OR INTERCEPT HAS BEEN PROVIDED INCORRECT INFORMATION AND/OR HAS ERRONEOUSLY TRANSFERRED FUNDS TO MY ACCOUNT, I AUTHORIZE INTERCEPT CORPORATION TO WITHDRAW/REVERSE FROM MY ACCOUNT THE AMOUNT OF FUNDS TRANSFERRED IN ERROR. I ALSO UNDERSTAND THAT IC MAY WITHDRAW AND/OR DEPOSIT TO MY ACCOUNT VARIOUS FUNDS REGARDING MY PARTICIPATION IN A FLEXIBLE BENEFIT/CAFETERIA PLAN/ERISA PLAN. I HEREBY HOLD INTERCEPT HARMLESS FOR TRANSFERRING ANY FUNDS DESIGNATED FOR FLEX BENEFITS UPON THE DIRECTION OF MY EMPLOYER OR PROCESSOR, AND THAT MY REMEDY FOR ANY ERRONEOUS TRANSFERS IS SOLELY AGAINST THE PROCESSOR AND/OR MY EMPLOYER AND THAT I WILL HOLD HARMLESS INTERCEPT FROM ANY LIABILITY AND DAMAGES RESULTING THEREFROM. I UNDERSTAND, AGREE, AND ACKNOWLEDGE THAT AS PART OF THE ACH PROCESS, ONCE FUNDS ARE DEBITED FROM THE BANK ACCOUNT SHOWN BELOW PURSUANT TO THIS AGREEMENT, SUCH FUNDS SHALL BE PLACED IN ONE OR MORE IC ACCOUNTS AT IC'S BANK AND THAT IC SHALL BE THE ONLY ENTITY AUTHORIZED ON SUCH ACCOUNTS. I FURTHER ACKNOWLEDGE THAT SUCH IC ACCOUNTS SHALL BE SUBJECT TO SETOFF BY IC'S BANK.



Electronic Funds Transfer (15 U.S.C. § 1693): I hereby acknowledge receipt of notice by the financial institution described here within of: (i) the undersigned's liability for an unauthorized electronic fund transfer, (ii) the undersigned's duty to promptly report such unauthorized transfers, (iii) the undersigned's liability for charges for electronic fund transfers, (iv) the undersigned's right to stop payment of pre-authorized electronic fund transfers, (v) the procedure to initiate such stop payment orders, (vi) the right to receive documentation of electronic fund transfers, and (vii) the Bank's liability pursuant to the Electronic Funds Transfer Act found at 15 U.S.C. § 1693, et al.

Limitation of Action: I acknowledge that I have 60 days from the date of a withdrawal from or deposit to the account shown below to dispute the withdrawal or deposit by contacting my employer and Intercept Corporation by telephone and later supplemented in writing, or in writing of any discrepancies, errors or disputes concerning any transfer of funds to or from any account processed by Intercept. This will include but not limited to, errors in amounts, erroneous transactions, or other transactions processed. All written notices must include the following information:

- a) The name of the company with whom the undersigned authorized the transaction, i.e., employer and/or third party;
- b) Federal Taxpayer ID number of the company authorized to make the transaction;
- c) Federal Taxpayer ID number of the undersigned;
- d) The name of the undersigned;
- e) The name, account number and ABA number on the transaction in question;
- f) The dollar amount of the transaction in question; and
- g) Description of the error and explanation of the error.

I understand and agree that my employer, its agent, or IC will inform me of the results of their investigation within ten (10) days of the receipt of the complaint and will correct any error promptly. I understand and agree that if my employer, and/or its agent, or IC need more time, IC may take up to 45 days to investigate the undersigned's complaint. For transfers initiated outside the United States or transfers resulting from point of sale or debit/access cards, the time periods for resolving errors will be 45 days and 90 days respectively.

Undersigned's Name

PNC

Financial Institution

City Denton, MD

Date

7/20/2017

Branch

Denton, MD

Phone Number

1-800-352-2255

054000030

Routing (ABA) Number

5349825614

Account Number

Account Type: Checking ☒ Savings ☐

Routing (ABA) Number

Account Number

Account Type: Checking ☐ Savings ☐

Undersigned's Signature

219-94-0620

Social Security Number

Please attach to this authorization a voided personal check for verification of all checking account information.