

## Authorization for Direct Deposit Form

**INSTRUCTIONS:** An authorization form must be completed for each direct deposit account. Complete each field on this form. Once completed fully, provide this form to your payroll administrator along with a copy of a voided check for the account, or a letter from the financial institution for confirmation of account information. Employees are responsible for notifying their financial institution of direct deposit from their employer.

1. **Employee Name:** \_\_\_\_\_

2. **Employee Social Security Number:** \_\_\_\_\_

3. **Employee Telephone Number:** \_\_\_\_\_

4. **Action to be Taken – Check one**

- Begin Direct Deposit
- Stop Direct Deposit
- Change Financial Institution
- Change Account Number

5. **Name of Financial Institution:** \_\_\_\_\_

6. **Bank Account Type – Check one**

- Checking
- Savings

7. **Bank Account Routing Number:** \_\_\_\_\_

*(Routing Numbers are 9 digits and located on a check)*

8. **Employee Account Number:** \_\_\_\_\_

9. **Amount to be deposited each pay – Check one and complete fields**

- Dollar Amount \$ \_\_\_\_\_
- Percentage \_\_\_\_\_ %

Unless otherwise indicated above, I hereby authorize and request [COMPANY NAME] hereinafter referred to as EMPLOYER, to direct the amount or percent of my net pay for crediting to my account indicated at the Financial Institution designated above, and I further authorize the Financial Institution to credit the same to such account without responsibility for correctness of such amount.

This authorization will remain in effect until I have given written notice that I am terminating this contract, or until Employer has notified me that this deposit service has been discontinued. I understand that I must give advanced notice to allow reasonable time for my instruction to be executed. If an incorrect deposit should be made into my bank account, I authorize my bank and Employer to make the appropriate adjustment(s). Furthermore, I understand that termination of employment with my Employer shall constitute sufficient authorization to terminate this agreement.

I agree to notify my Employer if I wish to change the designated Financial Institution or account to which my direct deposit is made, 30 days prior to the effective date of such change. I understand that failure to do so may delay the receipt of my deposit.

10. **Signature of Employee** \_\_\_\_\_

**Date** \_\_\_\_\_

**INTERNAL USE ONLY**

*Date Received*

*Effective Date of Direct Deposit*