DIRECT DEPOSIT FORM

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS OR TO DISCONTINUE AUTOMATIC DEPOSITS

An employee must present ID badge or state issued ID when submitting this form

EMPLOYEE INFORMATION

NAME (Last, First) _____ **EE#**: _____

☐ **START DIRECT DEPOSIT** (Primary account is the account where you have 100% or the Balance of your check being deposited into)

Bank Name:	Provide **one** of the following: (with Routing and Account #'s)	☐ Checking ☐ Savings	☐ 100% (Primary Account) ☐ Balance or ☐ Fixed amount: $ _____
_____	➢ A voided check ➢ Stamped direct deposit form completed by the bank or ➢ Official letter from the bank		

☐ **ADDITIONAL CHECKS** (When receiving additional check(s), I would like the money to be deposited into the following accounts:

	☐ Primary Account Only:	☐ Split between all accounts on file:

☐ **STOP DIRECT DEPOSIT** (I authorize Montefiore Nyack Hospital to terminate my direct deposit. I acknowledge this process may take 2 to 4 weeks to complete.)

Bank Name:	Routing#: _____ Account#: _____	☐ Checking or ☐ Savings	☐ 100% ☐ Balance or ☐ Fixed amount: $ _____
_____			

☐ **CHANGE DIRECT DEPOSIT**

Bank Name:	Change Request:	FROM: ☐ Fixed amount: $ _____	TO: ☐ Fixed amount: $ _____
_____			

COMMENTS SECTION:

REQUIRED APPROVAL

I authorize Montefiore Nyack Hospital, hereinafter referred to as COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated above and the depository named above, hereinafter called DEPOSITORY, to credit and/or debit the same to such account. This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

SIGNATURE: _____ DATE: _____

PHONE #: _____

HR OFFICE USE:

☐ Employee ID reviewed (ID Badge/Photo ID) HR Staff Initials: _____ Date: _____