

to you.

DIRECT DEPOSIT AUTHORIZATION

Ne	w Direct Deposit: Please attach docum	nentation (e.g. – a voided bank check or deposit slip or a copy of top
art	of bank statement) for confirmation of	banking information.
	Change an Existing Direct Deposit: documentation is not necessary.	Fill out the box(es) below with the requested change(s). Additional
1	☐ Savings Account	☐ Checking Account
	Bank Name	
	Bank Routing #	
	Account #	
	□ Dollar Amount \$	
2	☐ Savings Account	☐ Checking Account
	□ Dollar Amount \$	
3	☐ Savings Account	☐ Checking Account
	- · · · · ·	
	□ Dollar Amount \$	
the any fun exe	nuthorize Crouse Hospital to deposit any e financial institution indicated above. If y credit entries indicated by Crouse Honds erroneously into my account, I auth	y amounts owed me by initiating credit entries to my bank account Further, I authorize my financial institution to accept and to credit spital to my account. In the event that Crouse Hospital deposits corize Crouse Hospital to debit my account for an amount not to bus credit. This authorization is to remain in full force and effect un
	** NEW DIRECT DEPOSIT REC	QUESTS MAY REQUIRE 1 FULL PAY CYCLE TO PROCESS**
	ate Time	Signature

Form must be returned to the Payroll Department for processing.

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