Montefiore

MMC DIRECT DEPOSIT - APPLICATION /CHANGE FORM

EMPLOYEE NAME **Last** **First** **Mi.**	**Daytime Telephone No.**

EMPLOYEE NUMBER: _____

6-digit number (EZ Time ID#). This number can be found on the back of your Montefiore ID or pay stub.

A) NEW ENROLLMENT:

PERSON (S) NAMED ON THE ACCOUNT (print exactly as it appears on your check)

ACCOUNT TYPE **SAVINGS OR CHECKING (Circle only One)**

***ABA NUMBER** _____ **ACCOUNT NUMBER** _____

***Please confirm with your financial institutions that the ABA No. and account type is correct for Direct Deposit. Please attach a Voided personal check or a copy of a personal check.**

COPY OF SAMPLE CHECK ATTACHED

EMPLOYEE AUTHORIZATION:

By signing below, I hereby authorize my employer, Montefiore Medical Center (" Montefiore") to deposit my net pay directly into my checking or savings account each payday. If any monies to which I am not entitled are deposited into my account for any reason, including as the result of Montefiore's error I authorize Montefiore to direct the bank to return such funds directly to Montefiore in the full amount of the improper payment. This authorization allows Montefiore to direct my bank to return the funds at the time the overpayment is discovered, regardless of when the funds were improperly deposited into my account. I agree that this authorization will remain in effect until I provide my employer with written cancellation to terminate this service. I understand that 4 weeks must be allowed for implementation and any changes in direct deposit.

SIGNATURE_____ **DATE** _____

B) CHANGE OF ENROLLMENT:

PERSON (S) NAME ON THE ACCOUNT_____
ABA NUMBER _____
ACCOUNT NUMBER_____
_____**ACCOUNT TYPE SAVINGS OR CHECKING**
Circle only One

***Please confirm with your financial institution that the ABA No. and account type is correct for direct deposit. Please attach a voided personal check or a copy.**

SIGNATURE_____ **DATE**_____

C) CANCELLATION AUTHORIZATION:
I HEREBY AUTHORIZE MONTEFIORE MEDICAL CENTER TO CANCEL MY DIRECT DEPOSIT AUTHORIZATION AGREEMENT.

SIGNATURE_____**DATE:** _____

Please fax completed form to (914) 378-6485