Direct Deposit Authorization

Client Name: _____ Client #: _____

EMPLOYEE NAME: _____ **Last 4 Digits of SS #:** _____

I authorize_____, hereafter referred to as Employer, to deposit my periodic pay into the account identified as, and held, at the Financial Institution named below. I authorize that such account exists, and that the financial institution can make deposits without responsibility for correctness of such amounts.

My authorization will remain in effect until I give a written notice to terminate this agreement by providing my Employer in sufficient time and manner as to allow my Employer to act upon it. In addition, either my Employer, or the financial institution can terminate this agreement by providing me with their written notice at least 10 days prior to actual termination.

I also authorize Integrated Payroll Services, Inc. to debit the account if an amount of money was transferred to my account by mistake.

I have provided my Employer with a copy of a voided check solely for the purposes of verifying my account number and the Financial Institution's routing number.

☐ Initial Authorization

☐ Change of Financial Institution

☐ Change of Account Number

☐ Additional Bank Choice

_____ Deposit Entire Check

_____ Dollar Amount to Deposit

_____ Percentage to Deposit

Name of Financial Institution:		Phone #:
Mailing Address:		
City:	State:	Zip Code:
Account Type: ☐ **Checking** ☐ **Savings** ☐ **PayCard** ☐ **HSA**		
Routing #:	**Account #:**	

EMPLOYEE SIGNATURE: _____ **DATE:** _____

ACCOUNTHOLDER SIGNATURE: _____ **DATE:** _____
(Please complete if the Accountholder is someone other than the employee)

ATTACH A VOIDED CHECK OR LETTER FROM BANK

AS PROOF OF ACCOUNT NUMBER AND ROUTING NUMBER