Direct Deposit Authorization Agreement

Employee Name _____ **Employee #** _____

I hereby authorize IASIS Healthcare to initiate credit entries to my account(s). I also authorize, if necessary, debit/credit entries, adjustments, or payroll deductions for any credit entries processed to my account(s) in error. I acknowledge that the origination of ACH transactions to my account(s) must comply with the provisions of U.S. law.

Add _____ Change _____ Stop/Cancel _____

Name of bank, credit union, or savings and loan:

_____

Checking _____ (OR) Savings _____

Routing/Transit Number_____

Account Number_____

Fixed Amount $_____

(OR)

Percent of net pay amount _____%

Add _____ Change _____ Stop/Cancel _____

Name of bank, credit union, or savings and loan:

_____

Checking _____ (OR) Savings _____

Routing/Transit Number_____

Account Number_____

Fixed Amount $_____

(OR)

Percent of net pay amount _____%

I acknowledge that payroll will verify the routing, transit, and account numbers on the first payroll submission after authorization is given. This authorization is to remain in full force and effect until my employer has received written notification from me of its termination and I have furnished updated information to maintain a direct deposit. I understand that Direct Deposit changes can take up to 30 days to complete.

Date_____ **Employee Signature** _____

Please attach a voided check or a printed document from your financial institution indicating, the transit routing number, account number, type of account (checking or savings), and the account holder(s) name(s).

Note: Documentation cannot be hand written.

For Payroll Use Only

Date Received _____ Date Entered _____ Received By _____ Entered By _____