

# DIRECT DEPOSIT AUTHORIZATION FORM

Please Print Clearly

Name \_\_\_\_\_  
(first name) (m.i.) (last name/surname)

If you wish to deposit into more than one bank account, you must deposit a specific dollar amount or percentage into the Account #1 and the remaining balance will go into Account #2.

## ACCOUNT # 1

Bank or Credit Union  
Name \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

\_\_\_\_\_ Checking Account \_\_\_\_\_ Savings Account

Full Deposit \$ \_\_\_\_\_ Dollar Amount \$ \_\_\_\_\_ **OR** Percentage Amount % \_\_\_\_\_

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## ACCOUNT # 2

Bank or Credit Union  
Name \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

\_\_\_\_\_ Checking Account \_\_\_\_\_ Savings Account

Remainder

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**\*A voided check or bank direct deposit form showing the full routing and account number must be included with this form for each account.**

I understand that in the event my financial institution(s) is/are not able to deposit any electronic transfer into my account(s) due to any action I take, I understand that Capital Area Health Consortium cannot reissue funds to me until the funds are returned to them by my financial institution(s). If your account is credited in error, CAHC is authorized to debit my account for the same amount.

This authorization will remain in force until the CAHC is notified in writing to cancel the Direct Deposit.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date