Kaleida Health

DIRECT DEPOSIT

AUTHORIZATION & CANCELLATION FORM

For: Kaleida Health Federal Credit Union.

Fax # 859-5963

Name: *(print)*_____

Employee #:*(required)*_____

Location: *(required)*_____

By signing below, I authorize Kaleida Health to initiate direct deposit entries. If funds to which I am not entitled are deposited to my account, I authorize Kaleida Health to direct the bank to return the funds. I understand that my bank must be a member of the "Automated Clearing House (ACH)". I understand that all new accounts will go through a pre-notification process and I will be notified if there is a problem with my information.
This authorization is to remain in effect until it is changed or canceled by me via a Direct Deposit Authorization Form, my employment terminates, or Kaleida Health is notified by my bank. I understand that I must allow sufficient time for processing of changes and cancelation.

Employee Signature: _____ Date: _____

Bank Name: KALEIDA HEALTH FEDERAL CREDIT UNION

City: BUFFALO State: NY Zip: 14203

Routing # (9 digits): 022083649 ACH #: _____

Select one only:

Add New Account ☐

Change to existing Account ☐

Cancel Account ☐

Note: If an employee elects to change banks and cancel current direct deposit:

- **The employee is required to notify Kaleida with the new account information.**
- **The employee is also required to cancel old account information.**

Checking or Savings:

Checking Account ☐

Savings Account ☐

Amount to be deposited:

Net Pay 100%_____

Fixed/Partial Amt. $_____

Shares $ _____ **Share Draft $**_____ **Holiday Club $**_____

Vacation $_____ **Other $** _____ **Other $**_____

CREDIT UNION ACCOUNT# _____ **TELLER INITIALS** _____