Direct Deposit Authorization and Cancellation Form

Kaleida Health

Send to:
INFO@KALEIDAHEALTHFCU.ORG

Location:_____

Name: (print) _____ **Employee#:** (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 _____

Routing # (9 digits): 022083649_____ **Account No:**_____

Select One Only:

❑ Add New Account ❑ Change to existing Account ❑ Cancel Account

Checking or Savings:

❑ Checking Account

❑ Savings Account

Amount to be Deposited:

❑ Net Pay 100%

❑ Fixed/Partial Amt. $ _____

Note: If an employee elects to change banks and cancel current direct deposit:
- The employee is required to notify Kaleida Health with the new account information.
- The employee is also required to cancel old account information.

Credit Union Use Only:

Shares $_____ Share Draft $_____ Holiday Club $_____ Vacation $_____ Other $ _____ Other $_____

Credit Union Account #_____ Teller Initials _____