

Direct Deposit Authorization and Cancellation Form



Kaleida Health

Send to:

KHpayrollquestions@kaleidahealth.org

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 cancellation.

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 _____

