



DIRECT DEPOSIT PAYCHECK PROGRAM

****The form will not be processed without a voided check/bank document attached****

****This direct deposit will be effective the 2nd Pay Period following receipt of this authorization form****

I authorize my employer, HealthAlliance of the Hudson Valley to deposit my pay each pay period to the financial institutions (Bank) and account(s) listed below. In the event of an erroneous credit to my account, I authorize my employer to debit my account for the amount not to exceed the amount of the erroneous credit. I understand that the hospital cannot be held responsible for errors that may occur at the Federal Automated Clearing House or any member bank that may result from these transactions.

I understand that at least one pay cycle needs to occur before my paycheck will begin to be directly deposited to my bank account listed below. I further understand that I am not eligible for advanced paychecks and/or early distribution of paychecks (to accommodate vacation and shift schedules) because my pay is deposited directly into my bank account.

The hospital reserves the right to modify or terminate the Direct Deposit Paycheck Program at any time. This authority is to remain in full force and effect until the hospital receives written notification from me of its termination in such time and in such manner as to afford the hospital a reasonable opportunity to act on it.

Bank Name: _____

Bank Routing Number: _____

Account Number: _____

Status: ☐ New ☐ Additional* ☐ Change ☐ Stop

**This is an additional account to one or more that are currently active.*

 ☐ Checking ☐ Savings

 ☐ 100% Net Check ☐ Bi-Weekly Flat Amount \$ _____

Name: _____
(Please Print)

Employee No. _____

Signature: _____

Date: _____

Campus Payroll: HealthAlliance Hospital

RETURN COMPLETED FORM TO HUMAN RESOURCES