Direct Deposit Authorization Form

Dekalb Health utilizes a paperless pay program and requires all team members to set up some form of direct deposit. If you have a checking or savings account, please provide us with the account information.

NOTIFY PAYROLL IMMEDIATELY IF YOU CLOSE OR CHANGE YOUR BANK ACCOUNT!!

I hereby authorize Dekalb Health to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated below and the depository name below, hereinafter called depository, to credit and/or debit the same as such:

Employee Name as it appears on your account _____

Social Security Number _____

Please attach a voided check here, if possible

Account (check only one) _____ Checking _____ Savings

Financial Institution**:** _____

City, State & Zip Code: _____

Telephone: _____

ABA (Routing) Number: _____

Your Account Number: _____

The authority is to remain in full force and effect until Dekalb Health has received a submitted change in Kronos in such time and in such manner as to afford Dekalb Health and depository a reasonable opportunity to act on it.

Signed: _____ Date: _____