NORTH DIVISION HOUSE STAFF

DIRECT DEPOSIT - APPLICATION /CHANGE FORM

EMPLOYEE NAME Last First Mi.	Daytime Telephone No.

EMPLOYEE NUMBER: _____

6-digit number (EZ Time ID#). This number can be found on the back of your Montefiore ID or pay stub.

A) NEW ENROLLMENT:

PERSON (S) NAMED ON THE ACCOUNT (print exactly as it appears on your check)

ACCOUNT TYPE SAVINGS OR CHECKING (Circle only One)

*ABA NUMBER _____ ACCOUNT NUMBER _____

*Please confirm with your financial institutions that the ABA No. and account type is correct for Direct Deposit. Please attach a Voided personal check or a copy of a personal check.

COPY OF SAMPLE CHECK ATTACHED

EMPLOYEE AUTHORIZATION:
By signing below, I hereby authorize my employer, Montefiore Medical Center (" Montefiore") to deposit my net pay directly into my checking or savings account each payday. If any monies to which I am not entitled are deposited into my account for any reason, including as the result of Montefiore's error I authorize Montefiore to direct the bank to return such funds directly to Montefiore in the full amount of the improper payment. This authorization allows Montefiore to direct my bank to return the funds at the time the overpayment is discovered, regardless of when the funds were improperly deposited into my account. I agree that this authorization will remain in effect until I provide my employer with written cancellation to terminate this service. I understand that 4 weeks must be allowed for implementation and any changes in direct deposit.

SIGNATURE_____ DATE _____

B) CHANGE OF ENROLLMENT:

PERSON (S) NAME ON THE ACCOUNT_____

ABA NUMBER _____

ACCOUNT NUMBER_____

ACCOUNT TYPE SAVINGS OR CHECKING (Circle only One)

*Please confirm with your financial institution that the ABA No. and account type is correct for direct deposit. Please attach a voided personal check or a copy.

SIGNATURE_____ DATE_____

C) CANCELLATION AUTHORIZATION:
I HEREBY AUTHORIZE MONTEFIORE MEDICAL CENTER TO CANCEL MY DIRECT DEPOSIT AUTHORIZATION AGREEMENT.

SIGNATURE_____DATE: _____

Please fax completed form to (718) 365-4015 attn. Keila Fuentes.