

# DIRECT DEPOSIT

Authorization  Cancellation

Employee's Full Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Employee's Social Security #: \_\_\_\_\_ Paid Period:  Monthly  Semi-Monthly  Biweekly  Weekly

Net Pay Direct Deposit:  Savings  Checking

Financial Institution TRANSIT ROUTING NUMBER

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\_\_\_\_\_ Financial Institution

(between these symbols I: I: on the bottom of your check)

\_\_\_\_\_ Account No. at Financial Institution

Deduction amount \_\_\_\_\_

Savings  Checking

Financial Institution TRANSIT ROUTING NUMBER

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\_\_\_\_\_ Financial Institution

(between these symbols I: I: on the bottom of your check)

\_\_\_\_\_ Account No. at Financial Institution

I hereby authorize said employer to deposit the net amount of wages or salary due me at the end of each pay period directly to the account shown on the attached copy of a previously cancelled check. If any error in the amount of such deposit is made by said employer, I hereby authorize the financial institution to accept debit transaction as appropriate to correct such error. This authorization will remain in force until canceled in writing or changed by a new request. Notice of change or cancellation must be given at least 15 days prior to payday to the Payroll Department, Employer's Business Office.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

WHITE • Employer

YELLOW • Credit Union

PINK • Employee/Member



pefcu/cps-016

STAPLE VOIDED CHECK HERE  
or Copy of a Previously Cancelled Check Must Be Attached