

CHILD NUTRITION PROGRAM – DIOCESE OF BATON ROUGE

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Last Name

First Name

SSN

Bank Name	Transit/ ABA Number	State	Type of Account	Amount or Percent	Account Number
			[] Checking [] Savings		
			[] Checking [] Savings		
			[] Checking [] Savings		

Please Check One:

<input type="checkbox"/>	New or Additional Direct Deposit		
<input type="checkbox"/>	Change the Bank or Account Number on an Existing Direct Deposit	Account Number to be Replaced:	
<input type="checkbox"/>	Change the Amount of an Existing Direct Deposit	Amount Was:	Amount Changed To:
<input type="checkbox"/>	Other (please explain):		

I have attached a voided personalized check (checking accounts) or deposit slip (savings accounts) for each account specified. (This request will not be processed without the accompanying documentation.)

I hereby authorize the Company to directly deposit any salary or wages due to me, less any mandatory or authorized withholdings or deductions in the bank account(s) listed above in the percentages specified. (If two or more accounts are designated, deposits are to be made in whole percentages of pay to total 100%.)

The Company will credit my account(s) the amount of my payroll check on payday. The Company will provide me with a check stub on payday listing my deductions and pay. I understand that direct deposit is contingent each pay period on timely receipt of payroll hours and timely receipt of payroll funding from the client I am assigned to. Deposits are normally available the morning of pay date however each bank posts funds to accounts at different times daily, and the Company has no control over my bank's posting.

I authorize my financial institution to accept direct deposits to my account upon receipt and without advice to me. It is my responsibility to verify deposits on a per pay date basis before writing checks against these funds. I understand that the Company is not responsible for bank errors or bank fees. Banking services are provided in accordance with the limitations and restrictions of the Automated Clearing House Association.

This authorization is to remain in force until the Company has received written authorization from me of its termination or change. I understand that if my account has closed, my financial institution cannot accept a deposit on my behalf. If this occurs, my employer will not be able to process any further direct deposits without further written authorization from me. **IN ORDER TO TERMINATE OR REVOKE THIS AUTHORIZATION, I MUST NOTIFY MY EMPLOYER IN WRITING AT LEAST TWO WEEKS PRIOR TO THE TERMINATION.**

Signature: _____

Date: _____

Please verify with your bank that your first direct deposit has been processed correctly.