FLETCHER ALLEN HEALTH CARE
Direct Deposit Authorization

I authorize Fletcher Allen Health Care and the financial institution listed below to automatically deposit entries and to make corrective adjustments in the event of an overpayment to my account.

ATTACH VOIDED CHECK FOR EACH ACCOUNT

1. Deposit Net Pay to the following:

Bank Name ____________________________ Bank Transit/ABA no. ___________________________

Account No. ____________________________ Amount/percent ______ Checking____ Savings ____

ATTACH A VOIDED CHECK FOR ACCOUNT VERIFICATION

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2. Deposit fixed amount or percentage of net pay to the following:

Bank Name ____________________________ Bank Transit/ABA no. ___________________________

Account No. ____________________________ Amount/percent ______ Checking____ Savings ____

ATTACH A VOIDED CHECK FOR ACCOUNT VERIFICATION

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3. Deposit fixed amount or percentage of net pay to the following:

Bank Name ____________________________ Bank Transit/ABA no. ___________________________

Account No. ____________________________ Amount/percent ______ Checking____ Savings ____

ATTACH A VOIDED CHECK FOR ACCOUNT VERIFICATION

Name ____ Social Security No. ___________________

Signature _____________________________________ Date ______________________

Your direct deposit will take effect on the **First** Pay period after your request is received. This form must be received in Payroll no later than the Thursday prior to the pay date on which you would like this form to take effect.

TO CHANGE YOUR DIRECT DEPOSIT, SUBMIT A NEW FORM.

SEND THIS FORM TO THE: PAYROLL OFFICE, Smith 160 MCHV Campus
Phone: 847-3760 Fax: 847-4809 e-mail: payroll@vtmednet.org