DIRECT DEPOSIT FORM
DEACONESS HEALTH SYSTEM
Evansville, Indiana 47747

Please complete this form, print & sign, and attached your voided check.

EMPLOYEE NAME: ____ **ID #** ________

DEPARTMENT: ____

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## AUTHORIZATION TO DEPOSIT

**Please deposit my paycheck into my account at:** ________________________________________
**(Name of Bank)**

**If you are submitting changes, specify the paycheck effective date:** _________________________

**Signed:** ________________________________________________ **Date:** _____________________

**PLEASE NOTE:**

**To enter your Direct Deposit, we require the following information in printed form:**

1. **The routing number of your bank.**
2. **The account number for your checking account.**

**Please return a blank check with this form, with the word VOID written across the front of the check, <u>OR</u>, a deposit slip for your savings account (copies of these are accepted).**

☐ **Checking Account** ☐ **Savings Account**

ATTACH DOCUMENTATION HERE
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