CARE AND LIFE HOME HEALTH SERVICES

Employee Direct Deposit
Request

NAME: _____ BRANCH: _____

Complete the required information. Allow at least 2-3 weeks for processing. For checking accounts, a copy of a voided check must be provided. For savings accounts, a copy of a deposit slip must be provided.

DIRECT DEPOSIT 1

NAME OF BANK: _____

ABA#: _____ ACCOUNT #: _____

CHECKING _____ SAVINGS _____

ATTACH A COPY OF A VOIDED CHECK / SAVINGS DEPOSIT SLIP

In order for this direct deposit authorization to be valid, the name of the employee must be on the voided check or deposit slip. A notice from the bank authorizing the employee to deposit funds into the account will be accepted.

DIRECT DEPOSIT 2

NAME OF BANK: _____

ABA#: _____ ACCOUNT #: _____

CHECKING _____ SAVINGS _____

ATTACH A COPY OF A VOIDED CHECK / SAVINGS DEPOSIT SLIP

In order for this direct deposit authorization to be valid, the name of the employee must be on the voided check or deposit slip. A notice from the bank authorizing the employee to deposit funds into the account will be accepted.

I hereby authorize my employer to deposit any amounts owed me by initiating credit entries to my account at the financial. I hereby authorize my employer to deposit any amounts owed me by initiating credit entries to my account at the financial institution(s) listed above. Further, I authorize the financial institution(s) listed above to accept and to credit any entries indicated by Care and life LLC to my account. In the event that Care and life LLC deposits funds erroneously into my account, I authorize Care and life LLC to debit my account not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Care and life LLC has received written notice from me of its termination in such time and in such manner as to afford Care and life LLC a reasonable amount of time to act on it.

Employee Signature _____ Date _____