BOUNDARY Community Hospital

# DIRECT DEPOSIT AGREEMENT FORM

Employee Name: _____ Employee Number: _____

**Authorization Agreement:** I herby authorize Boundary Community Hospital to initiate automatic deposits to my account/s at the financial institution/s named below. I also authorize Boundary Community Hospital to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Boundary Community Hospital responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution, or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Boundary Community Hospital receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to Human Resources.

| **Primary Account** | **Secondary Account** |
|---|---|
| **Financial Institution:** | **Financial Institution:** |
| **Routing Number:** | **Routing Number:** |
| **Account Number:** | **Account Number:** |
| ☐ **Checking** ☐ **Savings** ☐ **Pay Card** | ☐ **Checking** ☐ **Savings** ☐ **Pay Card** |
| | **Dollar Amount: $** |

I hereby authorize Boundary Community Hospital to initiate deposits to my account as indicated on the voided/cancelled check I have included and the depository named above to credit the same to my account. I understand that details from the check/deposit slip will be used to verify the account details.

**Employee Signature**: _____ Date: _____

***Attach blank/voided check for authentication.***