

**NEW YORK CITY HEALTH + HOSPITALS**

**PAYROLL DIRECT DEPOSIT AUTHORIZATION AGREEMENT**

<b>INSTRUCTIONS:</b>  -For new enrollment..... fill in sections 1, 2, and 4. -For bank and/or account changes.....fill in sections 1, 3, and 4. -For termination of service.....fill in sections 1 and 5.  Email completed form and voided check to <a href="mailto:payrollinquiries@nychhc.org">payrollinquiries@nychhc.org</a>	<b>SECTION 1: EMPLOYEE INFORMATION</b>
	NAME: _____ LAST FIRST
	FACILITY: _____
	EMPLOYEE ID NUMBER: _____  WORK PHONE NUMBER : (_____) _____

**SECTION 2: NEW ENROLLMENT** (Attach a voided check/deposit slip or copy of savings account statement)

**ABA NUMBER**  
(9 digit number that appears on the bottom of your check or deposit slip just preceding your account #.)

<input type="text"/>	<b>ACCOUNT NUMBER</b>	<b>ACCOUNT TYPE</b>
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING

**SECTION 3: CHANGE OF:** (CHECK ALL BOXES WHICH APPLY)  BANK  ACCOUNT NUMBER  ACCOUNT TYPE  
(Attach a voided check/deposit slip or copy of savings account statement & fill in the boxes below)

**ABA NUMBER**  
(9 digit number that appears on the bottom of your check or deposit slip just preceding your account #.)

<input type="text"/>	<b>ACCOUNT NUMBER</b>	<b>ACCOUNT TYPE</b>
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING

**SECTION 4: EMPLOYEE AUTHORIZATION**

I hereby authorize New York City Health + Hospitals to deposit my net pay directly into my checking or savings account shown above and initiate (if necessary) debit entries and adjustments for any credit entries made in error to this account. I agree that this service authorization will remain in effect until I provide a written request to terminate this service or when I terminate employment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 5: TERMINATION OF SERVICE REQUEST**

I hereby authorize New York City Health + Hospitals to terminate my payroll direct deposit authorization agreement as soon as administratively possible.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR FACILITY PAYROLL DEPARTMENT USE ONLY**

<b>ENROLLMENT REJECTION:</b>	<b>ENTRY INFORMATION</b>
<b>NON-ELIGIBILITY</b> <input type="checkbox"/> Pre-note reject- List reason-List reason below	ENTERED BY: _____ DATE: _____
<input type="checkbox"/> Other- List reason below	Pre-note payroll: _____
Reason: _____	Eff. Payroll: _____
_____	Informed employee of rejection <input type="checkbox"/>
	Name: _____ Date: _____