DIRECT DEPOSIT FORM

GENERAL INFORMATION

Direct Deposits will be verified by the Banking Institution the pay period after it is received in the Payroll Department. New Direct Deposits and Changes to Direct Deposits will require approximately 2-3 pay cycles to take effect.

1. To start or change your Direct Deposit, attach a voided check. (Deposit slips **will not** be accepted).
2. Return this form to Seton Payroll Office located at Seton Healthcare Administration Building, 1345 Philomena Street, Suite 360, Austin, Texas 78723 or **FAX # 512- 406-0704**.
3. Do not close your account without notifying the Payroll Department. Doing so will cause an **interruption** in receiving your pay.
4. Incomplete forms **will not** be processed.

In order to establish a direct deposit with your banking institution, Payroll Services will initiate a pre-notification to your account. An entry will print on your bank statement for zero dollars from Seton indicating that a test has been completed to ensure that your Direct Deposit will process correctly. You will have received your last paper check on that date. This process is called **pre-notification** and is required for Direct Deposit.

I (We) authorize Seton Healthcare to credit my (our) account with the depository named below. If the Seton Healthcare erroneously deposits funds into my (our) account, I authorize Seton Healthcare to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period. I (We) will not close my (our) bank account without notifying payroll.

Signature: ____ **Date:** _____________________________________

SSN#: ____

Effective Date: ____________________________________

Print Name: ______________________________________ **Employee #:** ________________________________

Phone (Home): ____________________________________ **Phone (Work/Pager):** ________________________

CHECKING ACCOUNT INFORMATION

Checking Account – VOIDED CHECK OR A BANK REPRESENTATIVE SIGNATURE REQUIRED FOR PROCESSING

☐**START** ☐**CHANGE** ☐**CANCEL**

Transit#: __________________________________ **Account#:** ____

% Net Pay: ________________________________ **(or) Amount:** _______________________________________

Bank Representative Signature: ____ **Date:** ___________________

Title: ____

SAVINGS ACCOUNT INFORMATION

Savings Account – BANK REPRESENTATIVE SIGNATURE REQUIRED FOR PROCESSING

☐**START** ☐**CHANGE** ☐**CANCEL**

Transit#: __________________________________ **Account#:** ____

% Net Pay: ________________________________ **(or) Amount:** _______________________________________

Bank Representative Signature: ____ **Date:** ___________________

Title: ____

This authorization will remain in effect until Seton Healthcare has received written notification from you that it is to be cancelled in such time and manner for Seton Healthcare to act on it. Direct Deposits will be automatically cancelled after 90 days of employment termination. Fax: 512-406-0704.

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