Cabell Huntington Hospital

Authorization Agreement of
Automated Deposits (ACH Credits)

COMPANY NAME: **Cabell Huntington Hospital**

COMPANY ID NUMBER: 1550675666

_____ I hereby authorize direct deposit of my net wages by Cabell Huntington Hospital, Inc., specifically to initiate credit entries (and if necessary, debit entries and adjustments for any credit entries in error) to my (____) Checking/ (____) Savings (select one) account indicated below and the depository named below, hereinafter called Depository, to credit and/or debit the same to such account.

_____ I hereby revoke my authorization for direct deposit of my net wages by Cabell Huntington Hospital, Inc. (Check only if you have previously authorized direct deposit)

DEPOSITORY NAME: _____
(Name of your bank, credit union, etc.)

CITY: _____ STATE: _____

TRANSIT/ABA NUMBER: _____
(Nine digits)

ACCOUNT NUMBER: _____

This authorization is to remain in full force and effect until Cabell Huntington Hospital, Inc. has received written notification from me of its termination in such time and in such manner as to afford Cabell Huntington Hospital, Inc. and the Depository a reasonable opportunity to act on it.

EMPLOYEE NAME: _____ EMPLOYEE NUMBER: _____

SIGNATURE: _____ DATE: _____

Please return your completed form to the Payroll Office. Allow at least two weeks for processing.

FOR INTERNAL USE ONLY: PRE-NOTE SENT: _____ DATE: _____

PLEASE ATTACH A COPY OF A BLANK VOIDED CHECK
OR
PREPRINTED DEPOSIT SLIP (FOR SAVINGS ACCOUNTS)
MUST HAVE THIS TO DO DIRECT DEPOSIT!