PENNSTATE
The Milton S. Hershey Medical Center
The College of Medicine

DIRECT DEPOSIT AUTHORIZATION

For your convenience, The M.S. Hershey Medical Center allows employees to authorize automatic payroll and/or expense reimbursement to be deposited into their checking or savings accounts at almost any bank or financial institution in the United States. You may designate separate accounts for payroll and/or expense reimbursements. To have your payroll check deposited directly to your account you must:

1. Complete and sign the Direct Deposit Authorization below to authorize electronic fund transfer (EFT) **and**
2. Attach a **voided blank check(s)** **with account number and ABA # printed** on the slip and return to the Payroll Department, Academic Support Building, M.C. A440 or **fax it to 717-531-0442**. **Deposit slips will no longer be accepted.** For savings accounts documentation from the financial institution must accompany this form indicating account number and ABA#.

Any changes to your bank transit number or account number must be immediately reported in writing to the Payroll Department prior to closing your account. When changing your direct deposit, list all accounts you are currently using, noting what action you want to happen with each account (new, change, delete, or no change).

♦ DIRECT DEPOSIT AUTHORIZATION ♦

I hereby authorize The M.S. Hershey Medical Center (HMC) to initiate credit entries and to initiate, if necessary and with prior notice to me, debit entries and adjustments for any credit entries made by HMC in error to my account indicated below. I authorize the depository named below to credit and debit the same entries to such account.

ACCOUNT 1: ❑ New Account ❑ Change Account ❑ Delete Account ❑ No Change

Financial Institution Name: _____

ABA/Routing #: _____ Account Number: _____

Amount to Deposit: ❑ Full Deposit ❑ **Net Deposit** (if you have Partial Deposits into other accounts)

Type of Account: ❑ Checking ❑ Savings **Effective Date:** _____

ACCOUNT 2: ❑ New Account ❑ Change Account ❑ Delete Account ❑ No Change

Financial Institution Name: _____

ABA/Routing #: _____ Account Number: _____

Amount to Deposit: ❑ Full Deposit ❑ Partial Deposit $ _____ or _____%

Type of Account: ❑ Checking ❑ Savings **Effective Date:** _____

ACCOUNT 3: ❑ New Account ❑ Change Account ❑ Delete Account ❑ No Change

Financial Institution Name: _____

ABA/Routing #: _____ Account Number: _____

Amount to Deposit: ❑ Full Deposit ❑ Partial Deposit $ _____ or _____%

Type of Account: ❑ Checking ❑ Savings **Effective Date:** _____

ACCOUNT 4: ❑ New Account ❑ Change Account ❑ Delete Account ❑ No Change

Financial Institution Name: _____

ABA/Routing #: _____ Account Number: _____

Amount to Deposit: ❑ Full Deposit ❑ Partial Deposit $ _____ or _____%

Type of Account: ❑ Checking ❑ Savings **Effective Date:** _____

This authority is to remain in full force and effect until The M.S. Hershey Medical Center has received written notification from me of its termination. Such notification will allow The M.S. Hershey Medical Center a reasonable amount of time to act upon it.

SIGNATURE DATE

PRINT FULL NAME LAWSON ID #