CITY OF STACY

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION

Print Full Name: ____ **Employee No:** _____________

Email Address: ____

I wish to have my employer deposit my net pay and/or a fixed amount(s) each payday directly to my account(s) as indicated. I agree to notify my employer immediately of any changes to the information so that my pay may be properly distributed. I understand that in the event my employer notifies my financial institution that I am not entitled to the funds deposited to my account, my bank is authorized to debit my account for the amount of the adjustment. I understand that in the event my financial institution is not able to deposit any electronic transfer into my account due to any action I take, my employer can not issue the funds to me until the funds are returned to my employer by my financial institution.

Employee Signature _______________________________________ **Date** _____________

Please note that due to timing differences, new or changed direct deposits may receive one check after this form has been submitted. Please do not close account(s) without giving your payroll office two week's prior notice.

(You are not legally required to furnish the above information. This information is required if you wish to participate in the Direct Deposit Program)

This section should be completed by your financial institution for new/additional accounts when directing funds into a savings account or into a checking account if a voided personal check is not attached. Deposit slips can NOT be used.

Print name of Financial Representative: _______________________ **Phone:** ___________________

Signature of Financial Representative: ________________________ **Date:** ___________________

Percent of Net or Fixed Amount	Bank Name	Routing #	Account #	Checking/Savings

To be completed by the Payroll Clerk

Your direct deposit will start on ___/___/___ pay day.

Reviewed by: _________________________________ Date ____/____/____