



## Direct Deposit Agreement Form

### Authorization Agreement

I hereby authorize United Cerebral Palsy of Greater Sacramento to initiate automatic deposits to my account at the financial institution named below. I also authorize United Cerebral Palsy of Greater Sacramento to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold United Cerebral Palsy of Greater Sacramento responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until United Cerebral Palsy of Greater Sacramento receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

### Account Information

Employee Name: \_\_\_\_\_

Name of Financial Institution: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Checking

Savings

### Signature

Authorized Signature (Primary): \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Signature (Joint): \_\_\_\_\_ Date: \_\_\_\_\_

**Please attach a voided check and return this form to the Payroll Department**