$$

SAINT THOMAS HEALTH SERVICES
DIRECT DEPOSIT ENROLLMENT FORM

$$

_______________________________________ _______________________________________

Employee Partner name (Please Print) **Social Security Number or employee #**

{ } **NEW** application { } **CANCELLATION** { }**CHANGE** to previously submitted information

I hereby authorize my employer to deposit any amounts owed me by initiating credit entries to my accounts at the financial institution(s) (hereinafter referred to as "Bank(s)") indicated on this form. Further, I authorize Bank(s) to accept and to credit any credit entries indicated by my employer to my account(s). In the event that my employer deposits funds erroneously into my account(s), I authorize my employer to debit my account for the amount not to exceed the original amount of the erroneous credit. This authorization will remain in full force and effect until my employer and Bank(s) have received written notice from me of its termination in such time and in such manner as to afford my employer and Bank(s) reasonable opportunity to act on it.

____ ____________________

Signature **Date**

Account Information

You may choose up to four accounts. Must equal 100% or net pay.

A. ____Acct# ______________________________________

Bank Name & ABA Number

___ Checking ___ Savings I elect to deposit: $______.____ Or ___ Entire Net Amount.

B. ____Acct# ______________________________________

Bank Name & ABA Number

___ Checking ___ Savings I elect to deposit: $______.____ Or ___ Entire Net Amount.

C. ____Acct# ______________________________________

Bank Name & ABA Number

___ Checking ___ Savings I elect to deposit: $______.____ Or ___ Entire Net Amount.

D. ____Acct# ______________________________________

Bank Name & ABA Number

___ Checking ___ Savings I elect to deposit: $______.____ Or ___ Entire Net Amount.

Attach void check or deposit slip here for each of the specified accounts above.