Segnik Healthcare Services

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **Segnik Healthcare Services** to initiate automatic deposits to my account at the financial institution named below. I also authorize **Segnik Healthcare Services** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Segnik Healthcare Services** 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 **Segnik Healthcare Services** 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

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking ☐ Savings ☐

Signature

Authorized Signature (Primary): _____ **Date:** _____

Authorized Signature (Joint): _____ **Date:** _____

Please attach a voided check or deposit slip and return this form to the Payroll Department.