EVANGELICAL
COMMUNITY HOSPITAL
Excellence Every Day.

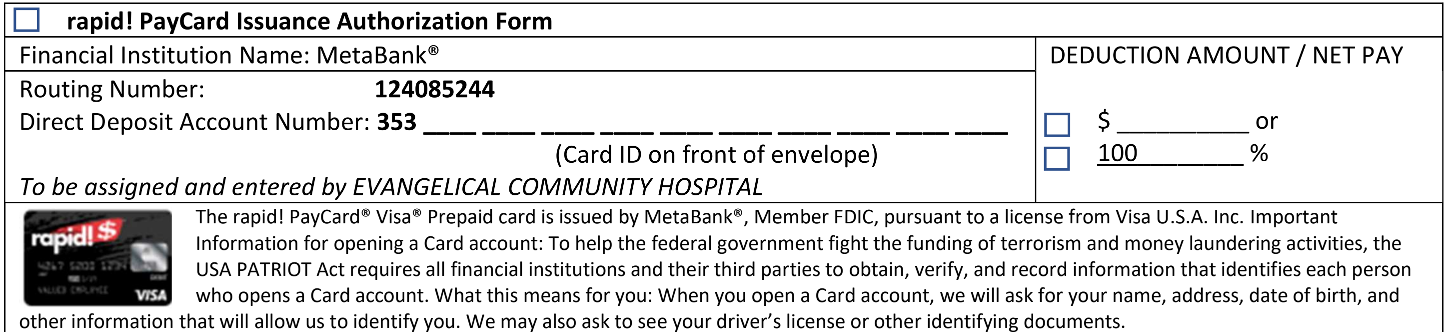
NET PAY DESIGNATION FORM

Employee Name:	**Effective Date:**
Address:	**City / State / Zip:**
Birth Date:	**Social Security Number:**
Phone:	**Email:**

CHOOSE YOUR METHOD OF DIRECT DEPOSIT:

☐ **I request my payroll deduction / direct deposit be placed in the following account(s):**				
BANK / CREDIT UNION	BANK ABA#	ACCOUNT #	DEDUCTION AMOUNT / NET PAY	TYPE OF ACCOUNT
	#	#	☐ $ __________ or ☐ __________ %	☐ Savings ☐ Checking
	#	#	☐ $ __________ or ☐ __________ %	☐ Savings ☐ Checking
PLEASE PROVIDE A VOIDED CHECK FOR EACH CHECKING ACCOUNT LISTED ABOVE.				

AND / OR:



☐ **rapid! PayCard Issuance Authorization Form**	
Financial Institution Name: MetaBank®	DEDUCTION AMOUNT / NET PAY
Routing Number: **124085244** Direct Deposit Account Number: **353** ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ (Card ID on front of envelope) *To be assigned and entered by EVANGELICAL COMMUNITY HOSPITAL*	☐ $ __________ or ☐ 100 ________ %

The rapid! PayCard® Visa® Prepaid card is issued by MetaBank®, Member FDIC, pursuant to a license from Visa U.S.A. Inc. Important Information for opening a Card account: To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires all financial institutions and their third parties to obtain, verify, and record information that identifies each person who opens a Card account. What this means for you: When you open a Card account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

☐ **LIVE CHECK -** Check this box and read and agree to the stipulations listed below.

Stipulations to receiving a live check:
1. All checks will be mailed via US Postal Services from Evangelical Community Hospital direct to your home address on file in the Payroll System. No reissue of live checks prior to **10 business days after pay day.**
2. Current bank fee for stop payment processing will be charged to the employee if check is lost and needs to be replaced. Current Stop payment fee is $33.00 per check processed and is subject to change according to bank fee schedule.

I authorize EVANGELICAL COMMUNITY HOSPITAL to withhold the indicated amount(s), if available, from my pay, and deposit directly into the account(s) shown and/or I hereby authorize EVANGELICAL COMMUNITY HOSPITAL to assign a rapid! PayCard and initiate credit entries and any correcting entries to my assigned rapid! PayCard account. The direct deposit(s) will be made on each payday unless I notify EVANGELICAL COMMUNITY HOSPITAL in writing of my intent to cancel. Upon EVANGELICAL COMMUNITY HOSPITAL's receipt of a request to cancel a direct deposit authorization, it shall become effective after a reasonable opportunity to act upon it.

In the event funds are deposited erroneously into my account, I authorize EVANGELICAL COMMUNITY HOSPITAL to debit my account(s) not to exceed the original amount of the credit.

I understand that EVANGELICAL COMMUNITY HOSPITAL reserves the right to refuse any direct deposit request. I also understand that all direct deposits are made through the Automated Clearing House (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

Note: If sending this form electronically, please type your initials and the last 4 digits of your social security number in the signature field. If sending or faxing a paper copy, please print out and sign your name(s) in the signature box.

Employee Signature: ____ **Date:** ____________________