



Payroll Distribution Authorization

Employee Name: _____ Date: _____

Social Security Number: _____ Phone: _____

I authorize Health Care **INNOVATIONS** to take the following action with my net salary:

Check One:

- 1. Issue a payroll check and mail to my address on file.
- 2. Deposit directly to my account(s) listed below. A pay stub remittance will be mailed.
(May take two pay periods to allow for pre-note process)
- 3. Change bank and/or account to which my net salary is deposited.
(You will receive a payroll check until new account is established) **DO NOT CLOSE ACCOUNT UNTIL PAYROLL CHECK IS ISSUED.**
- 4. Discontinue direct deposit and issue a payroll check instead.
DO NOT CLOSE ACCOUNT UNTIL PAYROLL CHECK IS ISSUED.

Direct Deposit Application (For accuracy, we recommend attaching a voided check)

Financial Institution: _____ Type of Account: ___ Checking ___ Savings
Routing Number: _____ % of net check or \$ _____
Account Number: _____

Financial Institution: _____ Type of Account: ___ Checking ___ Savings
Routing Number: _____ % of net check or \$ _____
Account Number: _____

I authorize Health Care **INNOVATIONS** to deposit my net salary to the bank and account(s) listed above. This authorization is to remain in force until Health Care **INNOVATIONS** receives notification from me of its termination in time and manner that allows **INNOVATIONS** and the bank a reasonable opportunity to act upon it. In the event that **INNOVATIONS** notifies the bank that funds to which I am not entitled have been deposited to my account in error, I authorize and direct the bank to return said funds to **INNOVATIONS** as soon as possible. If the funds erroneously deposited to my account have been drawn from that account so that return of those funds by the bank to **INNOVATIONS** is not possible, I authorize **INNOVATIONS** to recover those funds by deducting the amount erroneously paid me from any future payments from **INNOVATIONS** until the amount of the erroneous deposit has been recovered, in full. I understand that I will be responsible for any bank service fees that result from invalid or closed account information.

Employee Signature: _____ Date _____

Forward completed form to the payroll department of Health Care **INNOVATIONS**, 7701 Grand River Suite 100, Brighton, MI 48114. Phone number 810-227-7544, Fax number 810-227-4665.