

## PAYROLL DEDUCTION DIRECT DEPOSIT AUTHORIZATION

23 Division Street Saratoga Springs, NY 12866 518.583.2323 Fax: 518.583.9143 www.saratogafcu.org

Member Name:		Member Number: _		
Employer:		SSN/TIN:		
Home Phone:		Cell Phone:		
Initial	Authorizatio	n Chan	nge in Authorization	
deposit these funds at the Credit Ur further notice from me. I understand Authorization, I instruct my employe to cancel this Authorization upon fili and apply deductions in accordance increase or decrease the amount of	nion for each de that this Aurer to cancel ming for bankrue with this Aurer thou deduction for which the	payroll period follow thorization is revoca ny previous Authoriz uptcy, my employer athorization. I grant to on upon my written co e payment may vary	nts set forth in this Authorization and to wing receipt of this Authorization and until able. If this is a change in a previous exation and to follow this Authorization. If I fail and the Credit Union are directed to make the Credit Union a power of attorney to or verbal request. This power of attorney only y. I authorize my employer to honor any	
Deposit Amount: Net Check		\$		
Payroll Period: Weekly	Monthly	Biweekly	Semi-Monthly	
Deposit To: Savings	_ Checking	Account Number:	:	
Credit Union Routing and Transit N	umber: 2213	79659		
	redit Union to Account Nu		Effective Date  eduction for each pay period as follows:  Amount	
		Total Amou	unt:	
Credit Union Staff Only				
•	BOCES	SSCSD on _	(date). Staff Initials	