

LIMITED POWER OF ATTORNEY AND AUTHORIZATION FOR DIRECT DEPOSIT

(Please return to Human Resources at least one week prior to the payroll it is to be effective.)

Effective Date (Mo/Yr)	Social Security Number
Employee Name	Department Phone Number
Name of Financial Institution:	
Type of Account(s) (checking, savings, etc.). Please indicate amount split.	
<input type="checkbox"/> Checking No. _____ (\$)	ABA/Transit # _____
<input type="checkbox"/> Checking No. _____ (\$)	ABA/Transit # _____
<input type="checkbox"/> Checking No. _____ (\$)	ABA/Transit # _____
<input type="checkbox"/> Savings No. _____ (\$)	ABA/Transit # _____
<input type="checkbox"/> Savings No. _____ (\$)	ABA/Transit # _____
TRANSACTION TYPE	
<input type="checkbox"/> New Direct Deposit set-up	<input type="checkbox"/> Change Financial Institution
<input type="checkbox"/> Interagency Transfer	<input type="checkbox"/> Change Account Number
<input type="checkbox"/> Change Account Type	
<input type="checkbox"/> Cancellation	
<input type="checkbox"/> AUTHORIZATION	
I hereby appoint UTMB HealthCare Systems, (UTMB HCS) as my attorney-in-fact for the purpose of directly depositing my salary by electronic transfer and/or other means of direct deposit to the financial institution and in the account designated above to be effective on the date specified. This authorization and request to deposit my salary is not an assignment of my right to receive payment of my salary from UTMB HCS.	
I understand that UTMB HCS reserves the right to stop making deposits of my salary by electronic transfer and/or other means of direct deposit without advance notice. I also agree that my authorization to directly deposit my salary may not be withdrawn without at least one week prior to biweekly payroll written notice to UTMB HCS.	
I hereby authorize UTMB HCS to deduct from the designated account(s) or from my subsequent amounts deposited to the account(s) in error. In the event my designated account(s) is closed or contains an insufficient balance to allow a deduction for amounts deposited in error, then I agree that UTMB HCS may withhold any payments owing to me by UTMB HCS until such amount deposited in error is repaid.	
Payee SIGN HERE ➤	Date
<input type="checkbox"/> CANCELLATION	
I cancel the authorization to deposit to my account by electronic transfer any payments owing to me by UTMB HCS.	
Payee SIGN HERE ➤	Date

FOR OFFICE USE ONLY (Do not write below this line)

- PLEASE ATTACH CANCELLED CHECK HERE -