

New Enrollment

Change

Discontinue

Employee Name	Social Security Number
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**Please Note that a deposit ticket and a voided check must be attached for each account listed.**

**Account 1**

Bank/Credit Union/ S & L	Transit/ABA Number	Account Number
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Checking

Savings

Flat Dollar Amount
\$ _____ -

OR

Percentage
_____ %

**Account 2**

Bank/Credit Union/ S & L	Transit/ABA Number	Account Number
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Checking

Savings

Flat Dollar Amount
\$ _____ -

OR

Percentage
_____ %

**Account 3**

Bank/Credit Union/ S & L	Transit/ABA Number	Account Number
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Checking

Savings

Flat Dollar Amount
\$ _____ -

OR

Percentage
_____ %

**Account 4**

**The Remaining Amount Will Be Deposited Into This Account**

Bank/Credit Union/ S & L	Transit/ABA Number	Account Number
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Checking

Savings

I (we) authorized The UT-System Medical Foundation to credit my (our) account with the depository named above. If The UT-System Medical Foundation erroneously deposits funds into my (our) account, I (we) authorize the necessary debit entries, not to exceed the total of the original amount credited for the current pay period. The authorization will remain in effect until The UT-System Medical Foundation has received written notification from me (or either of us) that it is to be discontinued in such time and manner for the Medical Foundation to act on it.

Name				
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Address	City	State	Zip Code	Work Number
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Signature	Date
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