



Direct Deposit Authorization Form

Employee Information:

Employee Name: _____

Soc. Sec. Number ____ / ____ / _____

Direct Deposit Information:

Please deposit my wages/salary to the following bank account(s):

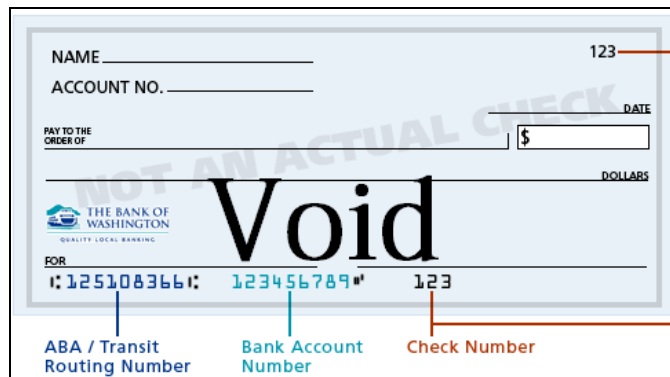
1st Bank – Bank Name: _____

<input type="checkbox"/> Checking	9 Digit Routing Number: _____	Account Number: _____	Indicate amount of direct deposit: _____% of Net Pay / \$_____ Set Amount / <input type="checkbox"/> Entire Pay
<input type="checkbox"/> Savings			

2nd Bank – Bank Name: _____

<input type="checkbox"/> Checking	9 Digit Routing Number: _____	Account Number: _____	Indicate amount of direct deposit: _____% of Net Pay / \$_____ Set Amount / <input type="checkbox"/> Entire Pay
<input type="checkbox"/> Savings			

Attached voided check(s) here:



Online Deposit Paystub Access (Employer On Demand)

Better Healthcare employees who receive direct deposit are able to view their pay stubs online using the Employer On Demand (EOD) website of <https://selfservice.employerondemand.com>.

Initial EOD Login Credentials:

EOD User name: Same user name as assigned for use in the Time & Attendance & BHCPort system.

EOD Initial Password: BHCare12

Note: EOD Users must change password after first login. Password must be at least 8 characters long, and contain one capital, one numeral and no part of the Employee's name)

Direct Deposit Acknowledgement:

I hereby authorize Better Healthcare OT/PT/SLP, PLLC (BHC) to deposit my payroll earnings using Payrolls Plus, Inc. into my account(s) at the bank(s) named above. BHC is authorized to reverse any deposits made in error to my account(s) through the company's direct deposit program. I further warrant that I am a holder on the account(s) listed above. I understand that deposit of my earnings into my account by Payrolls Plus maybe an advance of funds on behalf of BHC, which is subject to the full collections of these funds by Payrolls Plus from BHC's bank. I authorize Payrolls Plus to charge my account to recover said. I agree to hold Payrolls Plus harmless from loss and to indemnify it, limited to the amount of the deposit. It is understood that I may terminate this agreement at any time by written notification to the Better Healthcare OT/PT/SLP, PLLC Payroll Department.

NOTE: Please notify the Payroll Department immediately if you close your account(s).

➔ **Signature:** _____ **Date:** _____

Submit Form Via Fax to: (914) 373-6521 or

Mail to: Better Healthcare OT/PT/SLP, PLLC - Attn: Payroll, 10 Veschi Lane South, Mahopac, NY 10541