New Employee □

Change □

WESTERN HEALTH DIRECT DEPOSIT ENROLLMENT FORM

I hereby authorize the deposit of my payroll into the accounts below. I ensure that the information below is correct and **I will inform Payroll of any changes at least 2 weeks prior to payday.**

NAME: _____ EMPLOYEE# _____
SIN#: _____ SITE _____
SIGNATURE: _____
DATE: _____

	ACCOUNT 1	ACCOUNT 2	ACCOUNT 3	**NET PAY**
FINANCIAL INSTITUTION				
ADDRESS				
TYPE OF ACCOUNT				
ACCOUNT #				
AMOUNT $				**********

PLEASE NOTE: A VOID CHEQUE MUST ACCOMPANY THIS FORM FOR ANY CHEQUING ACCOUNTS BEING SET UP.