For Office Use Only

_____ Accts Payable

_____ Date

RETIREE AUTHORIZATION FOR AUTOMATIC DEPOSITS

PLEASE PRINT

NAME _____ ID# _____

ADDRESS _____

PHONE # _____ E-MAIL _____

SIGNATURE _____ DATE _____

I hereby authorize the Mt. Diablo Unified School District to deposit my medical reimbursement check electronically to the Financial Institution indicated on voided check below:

ATTACH VOIDED CHECK HERE

This authority is to remain in effect until you have received written notification from me of its termination.

- I understand that my reimbursement will be delayed if I change my bank account without notifying the district one month in advance.
- I understand that it will take two pay cycles for my direct deposit to take effect.

FOR DISTRICT ACCOUNTS PAYABLE USE ONLY – LEAVE BLANK

FINANCIAL INSTITUTION ROUTING NO. TRANSIT ABA	ROUTING NO. CHECK DIGIT	CHECKING ACCOUNT NUMBER