DIRECT DEPOSIT AUTHORIZATION BA

Payroll Office – The University of Michigan

To have your ***Medicare B Reimbursement payment*** direct deposited, complete the following information. ATTACH A BLANK, VOIDED CHECK/DRAFT(s) to this form and return it to the Payroll Office, G395 Wolverine Tower-Low Rise, 3003 South State Street, Ann Arbor, MI 48109-1279 or Fax: (734) 647-3983.

SECTION I: PERSONAL INFORMATION (Complete all information)

PRINT NAME – Last **First** **Middle** **UMID**

ADDRESS - Number Street City State Zip

SECTION II: ACCOUNT DATA FOR ONE FINANCIAL INSTITUTION

I choose to send my Medicare B Reimbursement Payment to the following institution.

Financial Institution	Account #	Type of account	Routing #
		☐ Checking* ☐ Savings**	

*** For checking/share draft accounts, YOU MUST ATTACH A BLANK, VOIDED CHECK/DRAFT.**
**For savings account, indicate Account # and Routing # (Obtain from your financial institution).

SECTION III: I authorize the deposit of my Medicare B Reimbursement to the institution indicated in Section II. I further agree to the following conditions:

1. THIS AUTHORIZATION IS TO REMAIN IN FORCE UNTIL CANCELLED BY ME.
2. The University reserves the right to recall or adjust any deposits improperly deposited to my account.
3. I authorize the financial institution(s) to honor any recall/adjustment request made by the University, and I hereby absolve the financial institution(s) from any liability that it might incur as a result of honoring such recall/adjustment request by the University.
4. I further authorize the financial institution(s) to withdraw monies available in any of my accounts at the institution in the event there are insufficient funds available, in the account designated to receive deposits, to cover the deposit error at the time of the recall/adjustment.
5. **ANY CHANGE TO THIS AUTHORIZATION MUST BE RECEIVED BY THE PAYROLL OFFICE AT LEAST TEN DAYS PRIOR TO THE PAYDAY** in which the University is obligated to honor this Authorization.
6. I absolve the University from any liability to pay charges for insufficient fund transactions that result from a failure within the Automated Clearing House network to correctly and timely deposit monies into my account.

Signature_____ **Date**_____