



UNIVERSITY HOSPITAL EMPLOYEES
FEDERAL CREDIT UNION

259 First Street • Mineola, NY 11501
(516) 663-2230 • fax (516) 663-4494
www.wuhfcu.org



PLEASE PRINT CLEARLY

Member _____ Member Acct. No. _____
Phone Home () _____ Work () _____ SSN/TIN _____
Email: _____ Employee ID. _____

Change of Distribution Initial Authorization Add to Existing Authorization Change in Authorization

I hereby authorize Winthrop-University Hospital to deduct from my salary the amounts set forth below and to deposit these funds at the Credit Union for each payroll period following receipt of this Authorization until further notice from me. If this is a change in a previous Authorization, I instruct Winthrop-University Hospital to cancel the prior Authorization and to follow this Authorization. If I fail to cancel this Authorization upon filing for bankruptcy, Winthrop-University and the Credit Union are directed to make and apply deductions in accordance with this Authorization.

Deposit Amount Net Check

\$ _____ Each Pay Period

X _____
Signature

Date

CREDIT UNION DIRECT DEPOSIT AUTHORIZATION

By signing above, I authorize the Credit Union to apply my payroll deduction for each pay period as follows:

Suffix	\$ _____
_____ Share Draft/Checking	\$ _____
_____ Share/Savings	\$ _____
_____ Money Market	\$ _____
_____ Loan # _____	\$ _____
_____ Loan # _____	\$ _____
_____ IRA _____	\$ _____
_____ Holiday Club _____	\$ _____
_____ Other _____	\$ _____
TOTAL	\$ _____

CREDIT UNION COPY