The Christ Hospital Health Network

ACCOUNTS PAYABLE

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

I hereby authorize The Christ Hospital Health Network (TCHHN) to Initiate credit or debit entries to my account with the Financial Institution Indicated below. This authority is to remain in full force and effect until TCHHN has received written notification from me of its termination in such time and in such manner as to afford TCHHN and the Financial Institution a reasonable opportunity to act on it. I understand this authorization is for a Federal Student Aid (FSA) credit balance. I further understand that it is my responsibility to notify Payables@theChristHospital.com and in the event of any banking changes.

Select One: Checking Account ☐ Savings Account ☐

Name of Financial Institution: _____

Routing No./Transit/ABA No. _____ Account No. _____

Payee (Student) Name _____

Student TCCNHS/TCHHN Email for remittance _____

Student Phone number for remittance information _____

Authorized Signature _____ Date _____

Attach a **voided check** for checking accounts **OR** **savings deposit slip** for savings accounts. Submit this form as an email attachment and attach a pic of your voided check or savings deposit slip and email to: Payables@TheChristHospital.com

Incomplete forms will not be processed. If ACH cannot be processed a check will be mailed to the address shown in SONIS.