Direct Deposit Authorization

[ ] New Direct Deposit [ ] Change Existing Direct Deposit [ ] Cancel Direct Deposit

Employee Information

Company Name So Cal Dental Partners	Company Number Division #_____	
Employee Name	Social Security Number	
Employee Number	Payroll Date Effective:	*Please Note: Changes to Direct Deposit may require a 10 banking day waiting period. You will continue to receive your paycheck as previously directed.*

Direct Deposit Information (Leave Blank if Cancellation)

Bank Name	Bank Branch	Account Type [ ] Checking [ ] Savings [ ] Money Market
Routing Number	Account Number	Deposit Amount [ ] Net Pay [ ] Fixed Amt. $ _____
If I have selected the "Fixed Amount" deposit option, I would prefer the balance in the form of: **[ ] A Check** **[ ] An Additional Direct Deposit (s) as follows:**		
Bank Name	Bank Branch	Account Type [ ] Checking [ ] Savings [ ] Money Market
Bank Name	Bank Branch	Account Type [ ] Checking [ ] Savings [ ] Money Market

Any funds in excess of the designated amounts above shall be remitted to me in a check.

I, the undersigned Employee of So Cal Dental Partners ("Employer") and a client of Telepayroll.com, Inc. hereby authorize the Payroll Department of Telepayroll.com, Inc. ("Payroll Department") to arrange for direct deposit of my paycheck to my bank account reflected on the attached VOIDED check.

I understand that neither the Payroll Department nor Telepayroll.com, Inc. shall be liable for (i) a paycheck returned by my bank or credit union as well as a result of insufficient funds in my employer's designated bank account; (ii) any error or negligent act of my Employer; (iii) any incorrect information given the Payroll Department or Telepayroll.com, Inc. by my Employer or me. I have read and agree to the terms on the back of this page.

Print Name: _____ Date:_____

Signature:_____

ATTACH A VOIDED CHECK