STATE OF WASHINGTON

# Authorization for Electronic Funds Transfer (EFT) of Wages

(Rev 11/08)

**See reverse side (page 2) for important information. Please indicate below if you would like to pick up your "test" check. If nothing is checked, check will be mailed to your home address. Please contact the payroll office if you have any questions.**

☐ **Pick-up "test" check in the payroll office.**

***Employee:*** *(1) Complete the upper portion of the form, sign, and date.*
*(2) Have your* ***financial institution complete the lower portion****; attach a* ***voided check*** *(see below)*
*(3)* ***Deliver the completed form to your Payroll Office.***

| PAYROLL NAME (Last, First, Initial) | EMPLOYEE ID NO* | AGENCY | AGENCY CODE |
|---|---|---|---|
| | | | |
| EMPLOYEE'S ADDRESS | | | DAYTIME TELEPHONE |

*Provide your employee identification number if available.

In accordance with RCW 43.41.180, I hereby authorize and request the State, until this authorization is revoked as described below, to transfer the full amount of my state salary, after mandatory and authorized deductions, to the designated financial institution for deposit in my account.

In the event that the State may be legally obligated to withhold any additional part of my salary payment for any reason, I understand that the State shall have the authority to immediately terminate any transfer made under this authorization.

If the State discovers that the *electronic transmission* for this authorization for any reason will result in an overpayment of salary or wages actually due and payable to me, I hereby authorize the State to either process a reversing transaction that will result in sending the net pay amount back to the state, or seek full reimbursement of the overpayment by whatever means is appropriate.

If any action taken by me or my financial institution, without adequate notification to my agency payroll office, results in non-acceptance of the transfer by the designated financial institution, I understand that the State assumes no responsibility for processing supplemental payroll payments until the funds are returned to the agency by the financial institution.

This authority is in force until written notification is received from me regarding its termination, or my death.

| EMPLOYEE'S SIGNATURE | DATE |
|---|---|
| | |

**Banking information can be provided in one of two ways:** ***Note: The completed form is valid only if items a) or b) are completed.***

a) Your financial institution completes the bottom section, or;
b) Attach a voided check. *Note: A deposit slip is not a valid substitution for a voided check.*

| NAME OF FINANCIAL INSTITUTION | CHECK THE TYPE OF ACCOUNT TO BE DEPOSITED: |
|---|---|
| | ☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT |

**FINANCIAL INSTITUTION TO COMPLETE ITEMS BELOW**

AUTHORIZED SIGNATURE OF FINANCIAL INSTITUTION REPRESENTATIVE TITLE/DATE

## IMPORTANT INFORMATION

**Bank Routing Number** **Account Number**