Health Alliance
Federal Credit Union
In Service to the Community

230 Highland Avenue, Somerville, MA 02143 (617) 591-6709,6710; Fax (617) 591-6711
www.myhacu.com

PAYROLL DEDUCTION AUTHORIZATION

Name:____ Account #:_______________________

Employer:_____________________________________SSN/TIN:__________________________

Somerville ______ Cambridge ______ Whidden ______ Other ______

Home Phone: ___________________________Work Phone:______________________________

START _____ STOP DEDUCTION_____ CHANGE DEDUCTION _____

The above named employer is hereby authorized to deduct the total amount indicated from my wages every pay period and to deposit these funds at the credit union following receipt of this authorization until further notice from me. If this is a change in a previous authorization, I instruct my employer to cancel my previous authorization and to follow this authorization. If I fail to cancel this authorization upon filing for bankruptcy, my employer and the credit union are directed to make and credit deductions as stated herein. I grant the credit union a power of attorney to increase or decrease the amount of my deduction upon my written or verbal request. I authorize my employer to honor any payment change made under this power of attorney.

Deposit Amount: $_______________________Payroll Period: Weekly _____ Bi-weekly _____

Credit Union Rourting / Transit #: 2113 8564 0

_______________ ____

Date Employee Signature

This deduction is to be credited as follows:

Share Savings	$____________	Checking	$____________
Club______________	$____________	Other_________	$____________
Club______________	$____________	Other_________	$____________
Loan#____________	$____________	Loan#________	$____________