INTEGRA HEALTH CARE

20730 Holyoke Ave. #125
P.O. Box 565
Lakeville, MN 55044

Phone: 952-985-0672
Fax: 952-985-0675
www.integrahc.com

PAYROLL AUTHORIZATION FORM

Employee Name: _____

I authorize Integra Health Care, Inc. and the financial institution name below to automatically deposit my net pay to my account. (This includes my authorization to Integra Health Care, Inc. to reverse any entries made in error.) This will remain in effect until I give written notice to cancel it.

Type of Account: ☐ Checking ☐ Savings ☐ Cancel ☐ Change

Financial Institution: _____

City: _____ State: _____

Staple Voided Check Here:

OR

Bank#: _____

Account#: _____

Please sign, date, and return this form to the office.

_____ _____

Employee Signature Date