Sycamore Township
Direct Deposit Authorization Form

HEALTH SAVING ACCOUNT

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____

Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: $ __per month __twice per month

Type of Account: HEALTH SAVINGS ACCOUNT

Date to Begin Direct Deposit: __/__/2025

Sycamore Township is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee's Signature: _____

Date: _____

SYCAMORE TOWNSHIP