

DIRECT DEPOSIT AUTHORIZATION FORM

Account Holder: SSN: _____ Telephone: _____
 Last Name: _____ First Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____

Bank Information: Bank Name: _____ Account Type: Checking _____ Savings _____
 Bank Account No.: _____
 Bank Routing No.: _____

Authorization:

- I hereby authorize Florida Atlantic University to direct deposit my refund to my account in the financial institution named above.
- I must provide written notification to Florida Atlantic University to terminate this agreement.
- Failure to provide written notification of any changes in account information causing a return of funds and charges to the university will result in my being billed for those charges.

Signature: _____ **Date:** _____

Please forward this form along with your voided check to the address above.

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