



# AUTHORIZATION FOR ELECTRONIC DIRECT DEPOSIT

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I authorize my employer to  
electronically credit my account at:

LA Healthcare Federal Credit Union  
P.O. Box 17159  
Los Angeles, CA 90017

Employer:  Good Samaritan Hospital  St. Vincent's Hospital  Other \_\_\_\_\_

Routing #: 322078011

Dollar Amount to be Deposited: \_\_\_\_\_

Account #: \_\_\_\_\_

Checking: \_\_\_\_\_

Net Pay: \_\_\_\_\_

Savings: \_\_\_\_\_

Member Name: \_\_\_\_\_

Employee Number: \_\_\_\_\_

Phone: \_\_\_\_\_

SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

This authorization will remain in effect until my employer receives written  
notification from me that this request is terminated.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date