EXHIBIT E

St. Clair County Community Mental Health Authority

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYROLL DEPOSITS

Employee Information

Check one: _____New Enrollment _____Change Account Information

Employee Number:_____

Name:_____
(as it appears on bank account)

Address:_____

Financial Institution Information

Financial Institution Name:_____

Address:_____

Account #:_____ **Routing #:**_____

Account Type: _____Savings _____Checking

Direct Deposit $: _____

A copy of a voided check or deposit slip must accompany this authorization

Authorization

I hereby authorize St. Clair County Community Mental Health to deposit my payroll earnings into the account listed above and if necessary debit entries or adjustments for any deposits made in error to my (our) account. This authority will remain in full force and effect until written notice from me has been received by the company in such a manner as to afford reasonable time to act on it.

Signature_____Date_____

In Office Use Only:
Verbal confirmation of banking information change by: _____ Date: _____

Chief Financial Officer Approval: _____ Date: _____
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