Reset

LSU Health New Orleans

PAYROLL DEDUCTION/DEPOSIT CANCELLATION

Employee's Name: _____

Employee's Last 4 digits SS#: _____ Effective Date: _____

EmplID: _____

Please mark next to the plan(s) that you would like to have payroll deduction/deposit cancelled on.

☐ Direct Deposit

Bank's Name:_____ Routing #: _____ Account # _____

☐ LSUHSC Foundation

☐ United Way

☐ Other _____

By signing below, I am authorizing LSU Health Sciences Center in New Orleans' Payroll Department to cancel the payroll deduction/deposit on the effective date for the plans indicated.

Signature: _____ Date _____

For Office Use Only

Deduction Code: _____