TERMINATION OF DIRECT DEPOSIT

Employee Name: _____ Employee Number: _____

Employer Name: _____

Employee Social Security Number: _____

I hereby authorize Niagara County to terminate the deposit of my Net Wages in the account in my name at the bank indicated below.

Indicate type of account (check one): _☐_ Checking _☐_ Savings

Name of Bank: _____

Account Number: _____

Branch Address: _____

Termination Date (Payroll Date): _____

Employee Signature: _____ Date: _____

This Termination Form must be received in the Niagara County Payroll Department, Niagara County Treasurer's Office 59 Park Avenue, Lockport, NY at least two weeks prior to the next available payroll.

For Office Use Only:

Termination Date: _____

Computer Date Input By: _____ Date: _____