DADE COUNTY FEDERAL
CREDIT UNION

DIRECT DEPOSIT DISTRIBUTION FORM

Member Name:	This should match with the name on the direct deposit transaction.
Member Number:	This should coincide with the account number on file with your employer.
Company Name: **Miami Children's Hospital**	
Intended Start Date:	Please allow 5 business days for processing. If left blank, distribution will begin on the next deposit.

I hereby request and authorize the distribution or the change to the existing distribution, as stipulated below by DADE COUNTY FEDERAL CREDIT UNION from my direct deposit amount each pay period.

List All Distributions

IMPORTANT!

* One acct. must have "balance" checked off.
* Distributions to DCFCU loans will be given the highest priority.
* Total amount received must be set up through your employer.

Member #	Acct	Amount
		$ *or* ☐ Balance
		$ *or* ☐ Balance
		$ *or* ☐ Balance
		$ *or* ☐ Balance
		$ *or* ☐ Balance
		$ *or* ☐ Balance
		$ *or* ☐ Balance
		$ *or* ☐ Balance
		$ *or* ☐ Balance

THE CREDIT UNION AND THE MEMBER AGREE TO INDEMNIFY AND HOLD HARMLESS THE EMPLOYER FROM ANY CLAIM OF DIRECT LOSS CAUSED AS A RESULT OF COMPLYING WITH SAID DISTRIBUTION.

Member Signature Date

Branch # _____ Operator # _____ Operator Signature_____