Enrollment Form

DPS

Employee Information

Print and Complete All Fields

First Name ______________________ MI _____ Last Name ______________________

Social Security Number __ __ __ / __ __ / __ __ __ __ Date of Birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Address ______________________ APT # ______________________
(P.O. Boxes Not Allowed)

City ______________________ State _____ Zip Code ______________________

Home Telephone __ __ __ - __ __ __ - __ __ __ __ Work Telephone __ __ __ - __ __ __ - __ __ __ __

E-mail ______________________

I am requesting ☐ Full amount of my pay loaded to my ALINE Card

I am requesting ☐ Partial amount of $ ______________________of my pay loaded to my ALINE Card.

Your ALINE Card will arrive via U.S. Mail within ten business days.

Please read and sign before submitting:

By accepting and using my ALINE Card, I agree to be bound by the terms and conditions outlined in the ALINE Cardholder Agreement. I hereby authorize ADP to credit any amounts owed to me, as instructed by my employer, by initiating credit entries to my ALINE Card. In the event that ADP loads funds erroneously to my ALINE Card, I authorize ADP and my employer to debit my card for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until ADP has received written notice from me of its termination in such time and in such manner as to afford ADP reasonable opportunity to act on it. I agree that I have reviewed, and understand the ALINE Cardholder Fees Summary.

Employee Signature: ______________________ Date: ______________________

NOTE: After completing the form, please return it to your employer.

FOR EMPLOYER USE ONLY

Tax Branch: _____ Company Code: _____ Employee ID Number: ______________________

Company Name: ______________________ Employer Contact: ______________________

Phone: ______________________ Fax: ______________________

E-mail: ______________________

Employer Signature ______________________ Date ______________________

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