



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 that the full amount of my pay be loaded to my ALINE Card. \_\_\_\_\_  
*Initial Here*

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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