



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.

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 _____