

# HEALTH CHOICES

## Direct Deposit Authorization Form

Employee Name:	Social Security #:
Telephone Number:	Employer:
Address, City, State, Zip	
E-mail:	

*I request my Section 125 reimbursement direct deposit be placed in the following account(s):*

Institution	Bank ABA Number	Account Number	Type of Account
	#	#	<input type="checkbox"/> Savings <input type="checkbox"/> Checking

**PLEASE PROVIDE A VOIDED CHECK FOR EACH CHECKING ACCOUNT LISTED ABOVE. WE WILL NOT PROCESS WITHOUT A VOIDED CHECK.**

**DO NOT USE A DEPOSIT SLIP, THE NUMBER COULD BE INVALID!**

I authorize my Section 125 Health FSA, Dependent FSA or Individual Health Premium reimbursements to be sent to the financial institution named above to be deposited in the designated account.

In the event funds are deposited erroneously into my account, I authorize my Section 125 provider to debit my account(s) not to exceed the original amount of the credit.

I understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution. I also understand that it is my responsibility to check my bank account for reimbursements.

Employee Signature:	Date:
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