Plan Year: ______
Direct Deposit Authorization

PO Box 587
Pittsford, NY 14534
Phone: (800) 836-8100
Fax: (585) 248-2488
Email: info@flexbene.com

- ☐ New Authorization
- ☐ Change Account
- ☐ Cancel Authorization

Instructions:
Please designate ONE account for the direct deposit of your HRA / Flexible Benefit Reimbursements.

You MUST include a voided check if electing a checking account OR a savings deposit slip for a savings account.

PLEASE NOTE: This is MANDATORY to be completed and updated for each plan year to continue receiving Direct Deposit Reimbursement Payments. Please fill out the information below and attached a voided check.

EMPLOYEE INFORMATION

Employer:	
Employee Name:	**Employee SSN:** XXX-XX- ____ ____ ____ ____
Email Address: (By providing your email address, you authorize M.A. Services to electronically provide deposit notifications)	

ACCOUNT INFORMATION

Financial Institution:	**Account Type:** ☐ Checking ☐ Savings
Branch (if available)**:**	**Bank Contact Number** (if available)**:**
Routing/Transit Number: (When in doubt check with your Bank)	**Account Number:**

EMPLOYEE AUTHORIZATION

I hereby authorize Flexbene™ to initiate credit entries and, if necessary, debit entries to reverse erroneous credits, to my account indicated above. This authorization shall remain in full force and effect until Flexbene™ has received written notification from me of its termination in a timely manner as to afford Flexbene™ and the financial institution a reasonable opportunity to act upon it OR until I no longer participate in flexible benefits plan for a period of 6 months.

Employee Signature: ____ **Date:** ____________________

Please attach a voided check or savings deposit slip HERE.

IMPORTANT:
Please notify us immediately if you close an existing account.
Failure to notify us will delay the processing of your reimbursement and result in charges to you for a new set-up.