



AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT REIMBURSEMENT

2320 BRIGHTON-HENRIETTA TOWNLINE RD
ROCHESTER, NY 14623 • PHONE: 1-800-473-9595

Please Check One: Set up new Direct Deposit Change Direct Deposit Account Cancel Direct Deposit

Please Check All that Apply: Flexible Spending Account Health Reimbursement Account QTE Account

EMPLOYEE INFORMATION

Employer Name:

Employee Member ID:

Last Name:

First Name:

MI:

Address:

City:

State:

Zip:

Phone Number:

BANK ACCOUNT INFORMATION

Name of Bank:

Transit ABA Routing #:

Account #:

Type of Account (*Please Check One*):

- Checking Account (*you must attach a voided check with pre-printed name, transit ABA routing # and account number*)
- Savings Account (*you must attach a deposit slip with pre-printed name, transit ABA routing # and account number*)

(Please allow 14 days after receipt by Benefit Resource, Inc. for bank pre-notification to be completed.)

AUTHORIZATION AGREEMENT

I hereby authorize Benefit Resource, Inc. to initiate credit entries to the bank account indicated above and, if necessary, to initiate debit entries and adjustment for any credit entries made in error to my account. This authorization is to remain in full force and effect until Benefit Resource has received written notice from me of its termination and has had a reasonable opportunity to act on it. I understand that this authorization cannot be processed unless it is completed in full and submitted with the necessary attachment. By authorizing any direct deposits, I certify that the reimbursed expenses qualify for reimbursement under IRS regulations, are for a qualifying individual, and will not be reimbursed from any other source.

Signature _____

Date: ____/____/____

Please return completed form to Benefit Resource, Inc. Retain a copy for your files.

Internal Use Only: Initial and Date _____ FSA/HRA _____ QTE _____