benefit management

Direct Deposit Authorization Form

Fax or mail the completed authorization form with a voided check from your checking account or a deposit slip from your savings account to: Benefit Management, LLC / Attn: FSA Claims Dept. / PO Box 1090 / Great Bend, KS 67530 / (620) 792-7053 (fax).

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip Code _____

Employer Name _____

Email Address* (This information is required) Notification of processing and fund transactions will be sent via email.

_____

Social Security Number _____-_____-_____

Work Phone _____-_____-_____

Effective Date _____-_____-_____
Month - Day - Year

New Request ☐ Change Request ☐ Cancel Request ☐

Name of Financial Institution _____

Checking Account ☐ Savings Account ☐

Account Number_____

Routing Number_____

Account Ownership Individual ☐ Joint ☐

Terms and conditions:

1. Your financial institution must be a member of an Automated Clearing House in order for you to participate in the Direct Deposit Program
2. You must complete this authorization form in its entirety. This completed form and a voided check from the account to be deposited is required to initiate direct deposit banking. Please allow up to 4 weeks to process this request. Claims submitted during the implementation period will be processed and sent to the account on record in the manner formerly issued.
3. If an electronic transfer cannot be deposited to your account, Benefit Management will investigate the cause and attempt corrective action. If Benefit Management cannot successfully complete a deposit, a substitute check will be mailed to you. This may cause you a delay in receiving funds. Pending resolution of the electronic transfer problem, you will continue to receive reimbursement checks in the mail. Reinstatement in the Direct Deposit Program will be determined on a case-by-case basis.
4. If a direct deposit is made in error, Benefit Management reserves the right to reverse such deposit.
5. It is your responsibility to notify Benefit Management immediately of any changes in your account.
6. You may cancel your participation in the Direct Deposit program at any time by completing this form and indicating the action is to cancel.
7. Benefit Management reserves the right to cancel your participation in the Direct Deposit program automatically. Your financial institution may also cancel this agreement.

I certify that I have read and understand the terms of this agreement. I authorize Benefit Management to initiate credit entries to the account indicated above for the purpose of reimbursement from my flexible spending account and/or health reimbursement arrangement.

X_____ Date _____

Employee/Accountholder Signature

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Attach a voided check from the account to be deposited