DIRECT DEPOSIT AUTHORIZATION FORM

EMPLOYEE INFORMATION (Please Print)				
EmployER Name:				
EmployEE Name:	**Lasts 4 digits of Employee SSN:**			

I wish to receive my plan payments by Direct Deposit. I hereby authorize Health Economics Group, Inc. (HEG) to originate electronic credit transactions to my bank (or credit union or savings & loan) account indicated below and to credit the same to such account. If necessary, HEG may make deductions from my account for any payments credited to my account in error. This authority is to remain in full force and effect until HEG has received written notification from me of its termination in such time as to afford HEG and my bank a reasonable opportunity to act on it.

If you elect the direct deposit option for receiving your payment, you will receive an "explanation of benefits" at the time of each deposit.

I would like direct deposit of my plan payments for the following plan(s).
Check the box for all that apply:

☐ Flexible Spending Arrangement (FSA) ☐ Health Reimbursement Arrangement (HRA)

☐ Qualified Parking Reimbursement ☐ Dental Assistance Plan

BANK INFORMATION (Please Print) Is this a change to a current authorization? ☐ Yes ☐ No

Bank Name:

Routing Number: (9 digits)									

Account Number:																				

Type of Account: ☐ **Checking** ☐ **Savings**

Signature: ______________________________ **Date:**__________________

DIRECT DEPOSIT ACCOUNT VERIFICATION

➢ PLEASE ATTACH A VOIDED CHECK IN THIS AREA SO THAT WE MAY VERIFY YOUR ROUTING AND ACCOUNT NUMBERS.

Staple voided or copy of voided check here

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