

Direct Deposit Authorization Agreement

This form may be used to authorize the deposit of reimbursement funds when you file manual claims under your benefit plan. It has no bearing on any direct deposit forms you may have completed for your employer's payroll.

Company Name: _____

Employee Name: _____

Social Security Number: - -

Copy this blank form as needed.
Please print all information.

Mailing Address: (number/street) _____
(city, state, zip) _____

Email Address: _____

This is a: New direct deposit. Change to an existing direct deposit with effective date of: ____/____/____.
 Cancellation of an existing direct deposit.

Bank / Financial Institution Name: _____

Bank / Financial Institution Address (city/state): _____

Type of Account: Checking Account (A voided check is required. Please attach below.)

Savings Account (A voided deposit slip is required. Please attach below.)

Be sure to notify us if this info changes so your direct deposit info stays current.

Account Number:

Include ALL digits, including any leading or trailing zeros. Length varies by financial institution.

Routing / Transit Number:

Routing / Transit number will be 9 digits in length.

See example check below for help in identifying these numbers.

By signing below, I am authorizing Savers Administrative Services, Inc. (Savers Admin) to deposit my claim reimbursements directly into the specified account at the bank listed above. If funds to which I am not entitled are deposited to my bank account due to error or any other reason, I authorize Savers Admin to direct the bank to return said funds. I understand that my reimbursement deposit may not be credited to my bank account for up to two business days after the deposit order has been issued. I understand that this authority will remain in full force and effect until Savers Admin has received written notice from me of its termination in such time and in such manner as to afford Savers Admin a reasonable opportunity to act on it. I understand it is my responsibility to notify Savers Admin of any future changes to my bank account or routing numbers. Should I fail to do so, I understand that the receipt of my reimbursement funds may be delayed, and that I will be responsible for reimbursing Savers Admin and/or my employer for any associated bank fees.

Employee's Signature _____

Date _____

➔ **Scan and email your completed form to flex@saversadmin.com or fax to 336-759-3999.** ←

Attach your voided check in this area.

ACCOUNT HOLDER NAME	0601
ADDRESS	
CITY, STATE ZIP	Date _____
EXAMPLE - Showing location of routing and account numbers.	
Pay to the order of _____	\$ <input type="text"/>
Dollars	
BANK NAME	
For _____	
⑆ 123456789 ⑆ 000987654321 ⑆ 0601	

If a voided check is not available, the account holder is responsible for verifying that the correct account and routing/transit numbers have been obtained from the bank or financial institution. Incorrect account or routing/transit numbers may result in bank fees and a delay in the receipt of reimbursements.

Routing/Transit # (Always 9 digits. Surrounded by ⑆) Account # (Can be up to 17 digits.) Check #. Matches # in upper right corner of check. (Not needed on this form.)