Direct Deposit Authorization Agreement

MAIL TO:	FAX TO:
PayFlex Systems USA, Inc. **Extend Health** **P.O. Box 3039** **Omaha, NE 68103-3039**	**PayFlex Systems USA, Inc.** **Extend Health** **(402) 231-4310** *(No Cover Page Required)* **Page 1 of _____**

I WOULD LIKE TO:

- ☐ **Authorize a new Direct Deposit**
- ☐ **Change an existing Direct Deposit**
- ☐ **Cancel an existing Direct Deposit**

FINANCIAL INSTITUTION:

Account Type: ☐ **Checking Account** | ☐ **Savings Account**
(Select One)

Name of Institution: _____ **Branch:** _____

City: _____ **State:** _____ **Zip Code:** _____-_____

Transit/ABA Number: _____ **Account Number:** _____
(See example below) (See example below)

Name of your Employer: _____

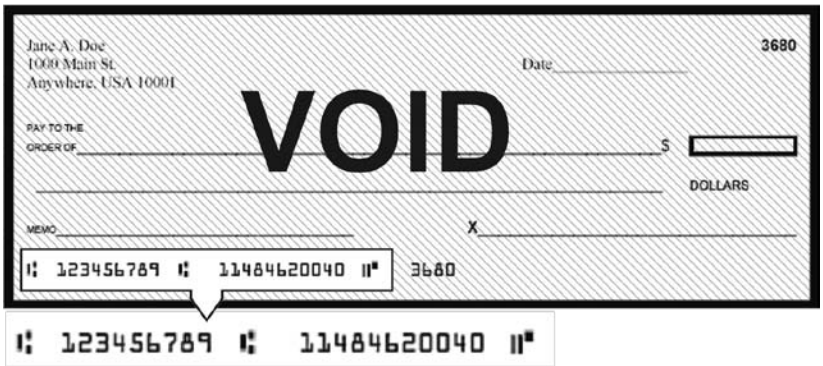
Name: _____ **Member Number:** _____
(Please Print Legibly) (May be your Social Security/Employer-Assigned Number)

I hereby authorize PayFlex Systems USA, Inc. (PayFlex) on behalf of Extend Health to initiate credit or debit entries to my account with the Financial Institution indicated above. This authority is to remain in full force and effect until PayFlex has received written notification from me of its termination in such time and in such manner as to afford PayFlex and the Financial Institution a reasonable opportunity to act on it. I understand this authorization is for reimbursements from my employer-sponsored reimbursement account plan.

Signature: _____ **Date:**_____

Attach a voided check for checking accounts or a savings account slip for savings accounts.

This form cannot be processed without information to the right.



Transit/ABA Number Account Number