Direct Deposit Request Form

To enroll in Direct Deposit for your Benefit Account, complete the form below. Attach a VOIDED Check (a deposit slip is not acceptable) for the account into which the reimbursement will be deposited. All information must be supplied in order for the direct deposit to be established.

I hereby authorize American Benefit Administrators, LLC. to deposit any amounts submitted by eligible receipts for reimbursement from my Health Reimbursement Account directly into the account designated on this form. Furthermore, I authorize my bank to accept and to credit any credit entries indicated by American Benefit Administrators, LLC. to my account. In the event that American Benefit Administrators, LLC. deposits funds erroneously into my account, I authorize American Benefit Administrators, LLC. to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until American Benefit Administrators, LLC. and the bank have received written notice from me of its termination in such time and in such manner as to afford American Benefit Administrators, LLC. and the bank reasonable opportunity to act on such notice.

Employee Name: ________________________________ Social Security #: ______________________

Employee Signature: ____ Date: ____________________

Employee Email Address: ________________________________

Bank Name/City/State:____

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Account Information (Select One)

❑ **Checking Account Routing/Account #:** ____

❑ **Savings Account Routing/Account #:** ____

email, fax or mail form to: support@americanbenefitadministrators.com
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