



Employee Benefit Management Services, Inc.

SECTION 125 (FLEX) DIRECT DEPOSIT AUTHORIZATION FORM

Phone 866-857-8182

Fax completed form to 877-236-9868

Name (Last, First, MI)	Group Name	Social Security Number
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Type of application (Select One Only)

- NEW:** Complete step 1, 2, & 3 and forward this form to EBMS. Allow two weeks from the time of EBMS' receipt of authorization and account information. Your direct deposit is in effect when you receive the first direct deposit verification. Reimbursements will be received in the form of a check until that time.
- CHANGE:** When changing your financial institution, Account Number or type of account, you must complete a new application. Complete step 1, 2 & 3 and forward this form to EBMS. Your direct deposit will be suspended and a check issued while the change is being verified. Do not close your old account until you receive a reimbursement check.
- CANCELLATION:** Fill out Name, Group Number, Social Security Number, signature & date and forward to EBMS. A cancellation should take effect within two weeks of EBMS' receipt of cancellation. Do not close your old account until you receive a reimbursement check.

1. Attach a voided check (or a copy of a check) below

DO NOT ATTACH A DEPOSIT TICKET.

A copy of a check is acceptable.

Attach a check here.

If a checking account, attach a check here. If a savings account please verify your "Routing Number" and "Account Number" with your financial institution.	
Checking	
Routing Number 9 digits	
Account Number	
Savings	
Routing Number 9 digits	
Account Number	

2. Select Payment Notification.

Select 1 method of Notification only (X)

<input type="checkbox"/> check here	Electronic Notification
E-mail Address:	

(initial) Please note, if you have selected "Electronic Notification", EBMS will forward electronic fund transfer information to you at the electronic address that you designate below. **Electronic fund transfer information contains protected health information.** Please be aware that if anyone, other than yourself, has access to the electronic address that you have provided to EBMS, they will be able to view any and all protected health information that is forwarded to that electronic address.

OR

<input type="checkbox"/> check here	Mailed Notification
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I authorize EBMS to deposit flexible spending reimbursements, by direct deposit (electronic funds transfer) into the designated financial institution and Account Number. I understand this authorization remains in effect until cancelled by: (a) me; (b) my death or legal incapacity; (c) the financial institution; (d) The Plan; or (e) upon separation from employment.
I authorize EBMS to recover money electronically deposited in my account in error, either by adjusting the account or withholding any future payments. I understand I will be notified in writing by EBMS if adjustments are being made.

Employee Signature	Date	Work Phone ()
		Home Phone ()