

Health Care & Dependent Care Spending Account Direct Deposit Authorization Agreement

Complete this agreement if you prefer to have your spending account reimbursement deposited directly into your bank account rather than receiving a check, or if you have experienced a change to your banking information. Direct deposit information will carry over from plan year to plan year. You **DO NOT** have to complete a new form each year.

Participant Information	
Participant Name:	Employee Number:
(please print clearly)	• •
Last Four Digits of Participant SSN#: Day	rtime Telephone: ()
Bank Information	
Bank Name:	Branch:
City:	State: Zip:
Type of Account (Check one):	☐ Savings
Routing/Transit Number: Accord	unt No.:
(9 digit number on lower left of check)	(Up to 17 digits)
Authorization	
	to remain in full force and effect until COMPANY has received rmination of this agreement in such time and such manner as to
Participant Signature	Date

ATTACH YOUR VOIDED CHECK OR SAVINGS DOCUMENTATION HERE

In order to process this agreement, you must provide a copy of a voided check for checking accounts and the participant's name must be imprinted on the voided check. With respect to savings accounts you must provide:

- (1) Documentation from the Bank that the participant is named on the account; and
- (2) A valid ABA# for electronic banking purposes.

Mail to: Spending Account Administrator, P.O. Box 67128, Los Angeles, CA 90067 Fax to: 1-855-729-9604

If you have questions, call Benefit Concepts at 1-866-629-6436, Monday through Friday, 5:30 a.m. to 6:30 p.m. PT.

BCIACH 10/16

