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#: _____ Daytime Telephone: (_____) _____

Bank Information

Bank Name: _____ Branch: _____

City: _____ State: _____ Zip: _____

Type of Account (Check one): ☐ Checking ☐ Savings

Routing/Transit Number: __ __ __ __ __ __ __ __ __ Account No.: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

(9 digit number on lower left of check) *(Up to 17 digits)*

Authorization

I hereby authorize Benefit Concepts ("COMPANY"), to initiate credit entries, and if necessary, make corrections for any entries made in error to my bank account. This agreement is to remain in full force and effect until COMPANY has received written notification from the participant of modification or termination of this agreement in such time and such manner as to afford COMPANY and the bank a reasonable opportunity to act on it.

_____ _____

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: 855-729-9604

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

BCIACH