

▶ Direct Deposit Authorization Form

Employer Name: _____

Participant Name (First, MI, Last): _____

Social Security Number: _____ - _____ - _____

Address: _____

City, ST, ZIP: _____

Date of Birth: _____/_____/_____ Phone Number (_____) _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Please check one:

Set up New Direct Deposit Change Direct Deposit Cancel Direct Deposit

Direct Deposit Election:

Type of Account (Check one): Checking Savings

Name of Bank: _____

Transit ABA Routing #: _____

Account #: _____

Participant Certification

By submitting this form, I hereby authorize Lifetime Benefit Solutions to deposit my reimbursements directly into the bank account indicated above and, if necessary, to withdraw amounts from the account in order to adjust for any amounts erroneously deposited. This authorization will remain in effect until Lifetime Benefit Solutions receives written notice from me of its termination. The set up process is approximately 10 business days.

Please retain a copy of this form for your records.

Participant Signature: _____ Date: _____

- **Mail to:** Lifetime Benefit Solutions, FSA/HRA Dept, PO Box 211126, Eagan, MN 55121 or
- **Fax to:** 877-256-7228.
- Call **Customer Service** with questions at 800-327-7130.

