Benefit Advantage
PO Box 5546 De Pere, WI 54115-5546
Phone (800) 686-6829
Fax (920) 339-0038
E-mail: claims@benadvan.com

Company Name: _____

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Print Your Name: _____

Print Your SS#: _____

Effective Date: _____

The information listed below is necessary to completely process the direct deposit funds into a specific bank account. (Please print all of the following information.)

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.

☐ New ☐ Change ☐ Cancel

☐ Checking (Must attach voided check) ☐ Savings (Please verify information with bank)

This information is for Benefit Advantage's use only and will not be disclosed to an outside party.

Transit ABA Routing #: _____

Account Number #: _____

Name of Bank: _____

I authorize my Section 125 Health Care FSA, Dependent Care FSA, Transit & Parking FSA, and/or Section 105 HRA reimbursements to be sent to the financial institution listed above and to be deposited in the designated account. I understand I may direct deposit to only one bank account.

In the event funds are deposited erroneously into my account, I authorize Benefit Advantage to debit my account not to exceed the original amount of the credit.

I also understand that all direct deposits are made though the Automated Clearing House (ACH), and that funds availability is subject to the limitations of the ACH as well as my financial institution. Benefit Advantage will not be held liable for any bank fees, overdrafts, etc… associated with these reimbursements.

Employee Signature: _____ Date: _____/_____/_____

Return this form to address or fax number at the top of the page.

You may review your account at www.benefitadvantage.com for balance details