



Authorization Direct Deposit

Enrollment, Change and Cancellation Authorization

Please read all information on this form carefully. Please print.

Authorization Information

Indicate by checking the appropriate box, whether you are enrolling for direct deposit, making a change to or canceling a previous authorization.

Enroll Change Cancel

Employee Information – Complete all the information below. Be SURE that your Social Security Number is included below.

Social Security Number - -	Name (Last, First, Middle Initial)	Home Telephone Number ()	Business Telephone Number ()
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Address (Street, City, State & Zip Code)

Employer

Account Information

Complete this section for direct payments to either your checking or savings account. Keep in mind that in order to take advantage of direct deposit, your bank MUST be a participating member of the AUTOMATED CLEARING HOUSE (ACH) Association. Please check with your bank to make sure they participate before completing this form. If you want your spending account reimbursements deposited into your checking account, please attach a voided check to this enrollment form.

Bank Name	Bank Address
Bank ID (first 8 digits of the routing number)	Bank SCD (Self-Checking Digit – the last digit of routing number)
Account Number	Account Type <input type="checkbox"/> Savings <input type="checkbox"/> Checking

Authorization Agreement for Direct Deposit of Benefit Payments - Read authorization and then sign and date below.

I hereby authorize Aetna Life Insurance Company to initiate credit entries to the account at the bank listed above for all flexible spending account reimbursements. This agreement will remain in effect until I give written notice to withdraw from the direct deposit service or until Aetna notifies me that this service has been terminated. I understand that I must allow reasonable time for my instructions to be executed. If ever Aetna credits more money than the correct benefit amount to the account due to duplicate or erroneous electronic funds transfers, I authorize Aetna to withdraw the overpayment. I authorize and request the bank listed above to accept any credit entries by Aetna to such account and to credit the same to such account. I understand that reimbursements will be credited three banking days after the regularly scheduled draft run, assuming I have a claim processed.

Authorized Signature _____ Date _____