AUTHORIZATION FOR DIRECT DEPOSIT (EFT)
CLAIM/DISTRIBUTION PROCESSING (OPTIONAL)

(PLEASE PRINT)

Complete this form only if you wish Alliance Benefit Group of Illinois to initiate a direct deposit/electronic funds transfer (EFT) when reimbursing for a qualified medical expense paid out-of-pocket.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Email Address:		

I hereby authorize Alliance Benefit Group (ABG) as program administrator to initiate credit entries as direct deposit claim reimbursements and to initiate, if necessary, debit adjustment entries made for any credit entry made in error to my account. These transactions are made through regional automated clearing house (ACH) associations and are subject to the operating rules and regulations of the National Automated Clearinghouse Association (NACHA).

I understand this change will not be effective until the third business day following receipt of the completed form by Alliance Benefit Group of Illinois. Where applicable, ACH returns will incur additional fees.

Please complete the appropriate sections (for new EFT, complete all):

_____

Name of Financial Institution

_____

Routing and Transit Number (9 Digits)

_____

Account Number *(Authorization applies to checking accounts only)*

I certify that I am the owner of the account named above and that I have the legal right to provide this authorization. This authority shall apply to all requests for claim reimbursements I submit to ABG under the Health Savings Account program. This authorization remains in full force and effect until which time ABG has received written notification from me of its termination. I agree to provide such notification of cancellation in such a manner as to afford Alliance Benefit Group reasonable time to act on it. Failure to notify ABG in a timely manner could result in additional fees.

Signature of Account Holder: _____ **Date:** _____

****A COPY OF A VOIDED CHECK MUST BE ATTACHED****

MAIL OR FAX A COPY OF THIS FORM TO:

ALLIANCE BENEFIT GROUP OF ILLINOIS, MyHSA DEPARTMENT, 456 FULTON STREET, SUITE 345, PEORIA, IL 61602
FAX (800) 688-4329

If you have any questions please call 800-57MyHSA (800-576-9472).