



**Health Reimbursement Arrangement/Flexible Spending Account
Direct Deposit Authorization**

Please complete & return to PayFlex Systems USA, Inc. There is no need to complete a new form for this plan year if you had the direct deposit feature with your flexible spending account last year. Direct deposit will become effective 3 weeks from the date of receipt.

I hereby authorize PayFlex Systems USA, Inc., Inc. to initiate credit entries or debit entries to correct errors, depositing my Flexible Spending Account reimbursements into my account designated below and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until PayFlex Systems USA, Inc., Inc. has received written notification from me of its termination in such time and such manner as to afford PayFlex Systems USA, Inc., Inc. a reasonable opportunity to act on it. Please check with your financial institution before drawing funds. The funds will **generally** be available 4 business days after the check date. PayFlex Systems USA, Inc. is not responsible for overdraft charges.

Employee Name:	SSN:
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Home Phone:	Work Phone:
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Please Indicate: <input type="checkbox"/> Initial Set Up <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Please Indicate: <input type="checkbox"/> Checking Account* <input type="checkbox"/> Savings Account**
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Bank Name	Bank Phone:
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Routing Number:	Account Number:
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***Checking Accounts: Please attach a VOIDED CHECK. Deposit slips are not accepted.**
****Savings Accounts: Please contact your financial institution for appropriate account & routing numbers.**

Employee Signature: _____	Date: _____
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**Please fax or mail this form & your voided check to:
301-564-5192 Fax
PayFlex Systems USA, Inc.
13511 Label Lane Suite 201, Hagerstown, MD 21740**

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