Direct Deposit Form for Health Savings Account (HSA) Reimbursements

WELLS FARGO

Use this form to enable Wells Fargo to deposit reimbursements directly into your checking account, or to change or cancel your direct deposit arrangement. Please complete the information below and attach an original or photocopy of a voided check.

Fax to the number below or mail to:
Wells Fargo Health Benefit Services, NW 5613, P.O. Box 1450, Minneapolis, MN 55485-5613

Contact Information

Name of Employer – If sponsored through an employer, otherwise enter "Individual"				Social Security #
Last Name	First Name	M.I.	Home Phone # (area code)	Work Phone # (area code)

As a *Health Savings Account (HSA)* participant, you may choose to have reimbursements directly deposited to your bank account. Direct deposit is a faster and more secure method than standard mailed checks. You will be notified by mail when your claim has been processed and funds have been deposited into your account. With this notice, you will receive the detail of the claim(s) and the amount paid.

Note: Please allow 14 days for direct deposit to be set-up for your account. Once direct deposit is established, all reimbursements will be processed by this method. If you would like to receive a reimbursement by manual check, you will need to cancel your direct deposit agreement by completing the *Direct Deposit Cancellation Request* section below.

Direct Deposit Set-up / Account Change Request
Complete this section to set up new direct deposit service or to change an existing direct deposit account.

Action Requested *(please attach original/photocopy of voided check)*:

☐ **Set-up Direct Deposit**	Effective Date of Action	
	Bank/C.U. Routing Number (9 digits)	Personal Account Number (as it appears on check)
☐ **Change Direct Deposit Account**	Effective Date of Action	
	New Bank/C.U. Routing Number (9 digits)	New Personal Account Number (as it appears on check)
	Old Routing Number	Old Account Number

I hereby authorize Wells Fargo Bank to directly deposit my HSA reimbursements to the account identified above and by the attached voided check. I understand that the notice of deposit is not a guarantee that funds have been received by my financial institution. I acknowledge that this authorization is binding and may only be altered or cancelled upon written notification from me to Wells Fargo Health Benefit Services.

Signature of Account Holder	Date

Direct Deposit Cancellation Request
Complete this section only if you are canceling your direct deposit agreement.

☐ **Cancel Direct Deposit**	Effective Date of Action

I elect to cancel my direct deposit agreement with Wells Fargo Health Benefit Services on the Effective Date listed above. I understand that I will thereafter receive my HSA reimbursements in the form of a check mailed to my home address.

Signature of Account Holder	Date

Web site: www.wfhbs.com/kaiserpermanente
Phone: (866) 890-8308
Fax: (888) 824-3868

Please attach original or photocopy of voided check.