



Reimbursement Account Authorization Agreement for Direct Deposit

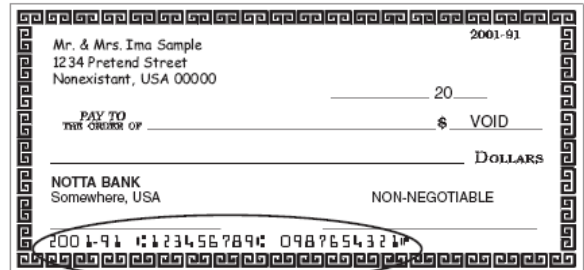
Health, HRA and Dependent Care Reimbursement Accounts

I hereby authorize First Administrators, Inc. to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to the account identified below. This election shall remain in force until revoked by me.

This agreement is: New Change Cancel

Account Number: _____ Transit ABA Routing #: _____

- The **Transit ABA Routing #** includes all of the numbers before the colon in the middle of the number. Be sure to include any zeroes at the beginning or end.
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Account Type: Checking Savings

Name of Bank: _____ Bank Phone: _____

If you are requesting direct deposit, you must attach a voided check for verification and reference. For any requests other than the beginning of your plan year, it will take two check cycles for the automatic deposit authorization to be processed.

Signature: _____ Date: ____/____/____

Printed Name: _____ Social Security #: _____

Employer Name: _____ Daytime Phone Number: _____

Complete, sign and send this form and a voided check for new and/or change requests to:

Flexible Benefits Department
First Administrators, Inc.
PO Box 8150
Rapid City, SD 57709-8150
Phone: (800) 658-3073
Fax: (605) 399-7920