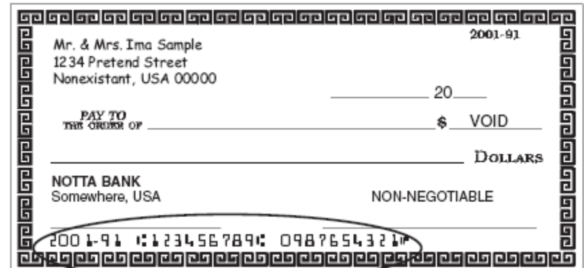
Reimbursement Account
Authorization Agreement for Direct Deposit

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. • The **Account Number** includes all of the numbers after the colon in the middle of the number. Be sure to include any zeroes at the beginning or end.	

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 9900
Sioux City, IA 51102-0479
Phone: (800) 941-4404
Fax: (712) 279-8479