AMERICAN BENEFITS GROUP

REIMBURSEMENT ACCOUNT
DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Employee Name:* _____
(Please Print)

Employee ID Number or Last four digits of SSN:* _____

Email Address (Used for Important Account Communications): _____

Employer:* _____

Banking Institution Name:* _____

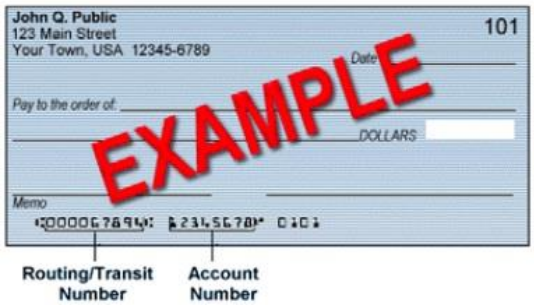
Banking Institution Address: _____
City State Zip

Routing/Transit Number:* _____

Bank Account Number:* _____

Type of Account: ☐ Checking
(check only one) **(please attach a Voided Check)**
☐ Savings

* *required field*



I hereby request and authorize American Benefits Group to remit by direct deposit to my bank named above any amounts due me for Flexible Spending (FSA), Health Reimbursement (HRA) and/or Commuter Transit & Parking Benefit reimbursement payments. I also request and authorize the Banking Institution to accept such deposits initiated by American Benefits Group and to direct such deposits to the designated account without responsibility for the correctness of the amount.

It is understood that this agreement may be terminated at anytime by written notification by me to American Benefits Group. Any such notification to American Benefits Group shall be effective only with respect to entries initiated by American Benefits Group after receipt of such notification and within a reasonable opportunity to act on it. Any such notification to the Banking Institution by the participant is unacceptable. The Banking Institution may terminate this agreement by written notice to the participant for Just Cause.

Signature: _____ Date: _____

Mail to: American Benefits Group | PO Box 1209 | Northampton, MA 01061-1209

Submit Securely by Email: processing@amben.com

800-499-3539