

Health Reimbursement Arrangement

**Direct Deposit Authorization**

**Employer Name:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

**SS #:** \_\_\_\_\_

**Street Address 1:** \_\_\_\_\_

**Street Address 2:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Authorization Agreement**  
for  
**Automatic Deposits**

I hereby authorize ASAP Flex Plans, Inc. to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account (identified below). Furthermore, I hereby authorize the Depository (the Bank identified below) to credit and/or debit the same to such account.

**Account #:** \_\_\_\_\_

**Transit #:** \_\_\_\_\_

**Depository Name:** \_\_\_\_\_

**Branch:** \_\_\_\_\_

**Street Address 1:** \_\_\_\_\_

**Street Address 2:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

This authority shall remain in full force and effect until ASAP Flex Plans, Inc. has received written notice from me of its termination in such time and in such manner as to afford both ASAP Flex Plans, Inc. and the Depository a reasonable opportunity to act thereon.

Date: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

**Please attach an unsigned, voided check here.**  
**Without the check, we will not process your request.**