



Direct Deposit Authorization Form

Overview

Use this form to:

- Request reimbursements to be sent directly to your bank account via Automated Clearing House (ACH).
- Update or change an existing bank account on file with EMPOWER. Please note that if there is already an account on file with EMPOWER, the new account will replace it.

Employee Instructions

1. Complete and sign this form.
2. Send the completed form, along with either a voided check or bank letter to EMPOWER by email (customerservice@empowerflex.com) or fax (316) 687-2113.

! *This form must be accompanied by either a voided check or a letter from the bank. The check or bank letter must match the account listed below.*

Employee Information

Employee Name _____	SSN (last four only) _____
Employer Name _____	

Account Information

Bank Name _____		
Street _____		
City _____	State _____	Zip Code _____
Routing Number _____	Account Number _____	
Checking	Savings	

I wish to enroll in the direct deposit program whereby plan reimbursements will be sent directly to my bank account. I authorize EMPOWER, A Family Health America LC Company, to send funds to my account by ACH transfer. I understand that in the event of error, EMPOWER may make adjustments to the account indicated above.

This agreement will remain in effect until EMPOWER has received my written notification to terminate the arrangement (with necessary time for EMPOWER and my bank to make the change).

I understand that I must notify EMPOWER in writing if any of the above information changes. If I fail to do so, this may result in a returned ACH fee of \$30 per incident. If this occurs, EMPOWER will invoice my employer for the \$30 fee and I will be responsible for reimbursing my employer.

Signature _____ Date _____