Direct Deposit Application Form

_____
Employer Name

_____ _____ _____
Employee Name (Please type or print) Social Security # Daytime Telephone #

NOTE: Account changes must be received two weeks prior to the date the change is effective. Changes received after this date may result in a check issued for reimbursement submitted. If changing accounts, please verify the deposit to the new account before closing the old account. (**IMPORTANT:** Complete entire form even if only making a change.)

Please complete this form and send to HealthSmart Benefit Solutions.

CHECKING ACCOUNT: Attach a **voided check** and record the transit number for that account on this form. It is a 9-digit number that appears at the bottom left of your check between the markings |: |: (Transit number cannot begin with "5.") If you are not sure which number to use, contact your financial institution for assistance prior to submitting this form.

SAVINGS ACCOUNT: Attach a **savings deposit slip** and record the transit number for that account on this form. It is a 9-digit issued by your financial institution.: (Transit number cannot begin with "5.") If you are not sure which number to use, contact your financial institution for assistance prior to submitting this form.

MONEY MARKET ACCOUNT: This is a type of checking account. Record a 9-digit transit number issued by your financial institution, and the money market account on this form. (Transit number cannot begin with "5.") **Please confirm these numbers with your financial institution prior to submitting this form.**

Account Information

Action: ☐**New Account** ☐**Change/Correct Account** ☐**Cancel Direct Deposit**

Account Type: ☐**Checking** ☐ **Savings** ☐**Money Market**

Effective Date _____

Bank Name and Address _____

Routing # (9 digits) _____ Account # _____

The entire balance of each reimbursement will be deposited into the account designated above.

Authorization Agreement: I hereby authorize HealthSmart Benefit Solutions to deposit my reimbursement direct into the account named above. This authority will remain in force until I have given written notice that I have terminated it, or until my employer has notified me that this deposit services has been terminated. I understand that I must give advance notice to allow responsible time for my instructions to be executed. If ever an incorrect amount should be entered into my account, I authorize my bank to make the appropriate adjustment(s).

Employee Signature _____ Date _____

Please attach a voided check (Checking) or savings deposit slip (Savings)
Send this form to HealthSmart Benefit Solutions, PO Box 3262, Charleston, WV or Fax to (877) 587-4434