DIRECT DEPOSIT REQUEST FORM

Employer Name: _____

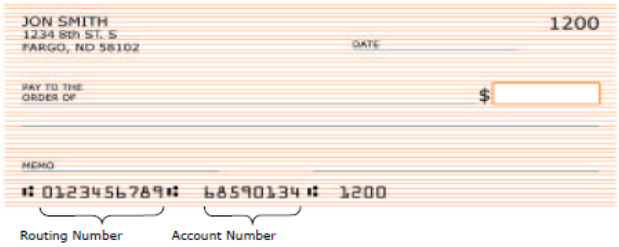
Employee Name: _____
First Last Middle

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____-_____ Email: _____

Bank Name: _____

Account Type: ☐ Checking ☐ Savings



Routing Number: _____ Account Number: _____

This account information will be used to issue claim reimbursements via direct deposit. If Banking information is not provided, reimbursements (for items not purchased with the benefit debit card) will be made via a paper check, mailed to the participant address on file.

I hereby certify the information provided on this form is accurate. Further, I understand my completion and submission of this form authorizes Benefit Solutions, Inc. to issue payment directly to the specified account unless I notify them otherwise.

Signature: _____ Date: _____

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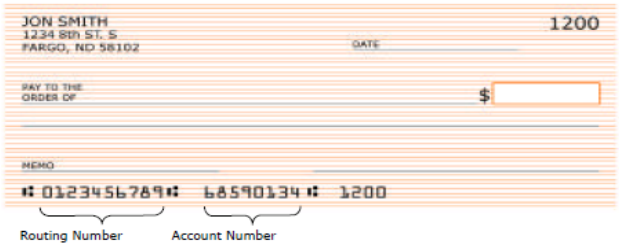

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