HealthPlans, Inc.

Direct Deposit Authorization Form

Flexible Spending Account/Health Reimbursement Account

Employer/Company Name	***Employee's SSN***
Employee Last Name	***Employee First Name***

I hereby authorize Health Plans, Inc. to deposit my Flexible Spending Account and/or Health Reimbursement Account claim payment owed to me by initiating a credit entry to my account at the financial institution (hereinafter "Bank") indicated below. Further, I authorize Bank to accept and to credit any credit entry initiated by Health Plans, Inc. to my account. In the event that Health Plans, Inc. deposits funds erroneously into my account, I authorize Health Plans, Inc. to debit my account for an amount not to exceed to original amount of the erroneous credit.

This authorization is to remain in full force and effect until Health Plans, Inc. and Bank have received written notice from me of its termination in such time and in such manner as to afford Health Plans, Inc. and Bank reasonable opportunity to act on it.

Account Information

Bank Name		
Bank Address		
Bank's Routing/Transit Number		
Employee's Bank Account Number	☐ ***Checking***	☐ ***Savings***

Please attach a voided check from your account

Employee Signature *(required)*

Date

Print and submit this form to:

Health Plans, Inc.
Attn: Flexible Spending/HRA Dept.
PO Box 5199
Westborough, MA 01581

or fax to: 508-329-4815

Please retain a copy of this form and all related documentation for your records.

*Questions? Please call **877-734-7004**, or submit your question online at **HealthPlansInc.com**; just click on **Contact**.*