Direct Deposit Authorization Agreement

Extend Health®

Mail to: Extend Health
P.O. Box 2396
Omaha, NE 68103-2396

Fax to: Extend Health
855-321-2605
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I would like to:

❑ Authorize a new Direct Deposit

❑ Change an existing Direct Deposit

❑ Cancel an existing Direct Deposit

Financial Institution Name /Branch: _____

Account Type: (Select one) ❑ Checking Account ❑ Savings Account

City: _____ State: _____ Zip Code: _____

Transit/ABA Number: _____ Account Number: _____

Name of your Employer: _____

Name: _____

Member Number: (e.g. Social Security) _____

I hereby authorize PayFlex Systems USA, Inc. (PayFlex) on behalf of Extend Health to initiate credit or debit entries to my account with the Financial Institution indicated above. This authority is to remain in full force and effect until PayFlex has received written notification from me of its termination in such time and in such manner as to afford PayFlex and the Financial Institution a reasonable opportunity to act on it. I understand this authorization is for reimbursements from my employer-sponsored reimbursement account plan.

Signature: _____ Date: _____

Attach a voided check for checking accounts or a savings account slip for savings accounts. This form cannot be processed without this information.