

DIRECT DEPOSIT REQUEST

## Authorization Agreement For ACH Debits/Credits

I, hereby authorize Ameriflex, hereafter called ADMINISTRATOR, to initiate debits and/or credits to or from my Bank Account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and or credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge the the origination of ACH transactions to or from my account must comply with the provisions of U.S. law.

Employer Name:					
Employee Name:	SSN (last four digits):				
Depository Name: _	Account Name:				
City:	S	tate:		Zip:	
Routing Number (alv	Account Number:				
Select One: Checking If you would prefer, p	ount	1:123456789 routing number			
the employee named	to remain in full force and effect d above of the termination in s asonable opportunity to act o	uch time a			
Employee Signature				Date	
Please mail, email o	or fax original to:				
Mail Ameriflex P.O. Box 269009 Plano, TX 75026	Email forms@myameriflex.com	<b>Fax</b> 800.282	2.9818		

Upon receipt, the Federal Reserve requires 14 business days to perform the initial approval of the ACH information. After this time, Ameriflex will be directly depositing all claim reimbursements into the bank account provided two days after every processing date determined by your employer.

It may take up to 5 business days to have your reimbursements appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. Ameriflex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.

