

**EMPLOYEE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS**

**EMPLOYER'S NAME** \_\_\_\_\_

I (we) hereby authorize Benefit Extras, Inc., hereinafter called COMPANY, to initiate credit entries to the account indicated below at the named depository financial institution hereafter called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Bank Name \_\_\_\_\_ Branch \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Routing Account  
Number \_\_\_\_\_ Number \_\_\_\_\_

Checking Account / Savings Account

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

**EMPLOYEE'S NAME** \_\_\_\_\_

(Please Print)

Date \_\_\_\_\_ Signature \_\_\_\_\_

I wish to cancel Direct Deposit

**NOTE: WRITTEN CREDIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.**

**Please send or fax completed form along with a copy of a voided check or savings deposit slip to:**

**Benefit Extras  
PO Box 1815  
Burnsville, MN 55337  
Fax: (952) 435-8435**

**(Please retain a copy for your records)**

*It does take approximately 12-14 days once Benefit Extras receives this form until the direct deposit becomes effective.*

*Any claims submitted prior to it being in effect will be paid via check.*