



Toll Free: (877) 505-9500
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www.cdhplans.com

Direct Deposit Authorization Form

Employee Name:	Social Security #:
Telephone No:	Employer:
Address, City, State, Zip	
e-mail:	

I request my Section 125 reimbursement direct deposit be placed in the following account(s):

Institution	Bank ABA Number	Account Number	Type of Account
	#	#	<input type="checkbox"/> Savings <input type="checkbox"/> Checking

PLEASE ATTACH A COPY OF A VOIDED CHECK.

I authorize my Section 125 Health FSA, Dependent FSA, Individual Health Premium or Transportation /Parking reimbursements to be sent to the financial institution named above to be deposited in the designated account.

In the event funds are deposited erroneously into my account, I authorize my Section 125 provider to debit my account(s) not to exceed the original amount of the credit.

I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

Employee Signature:	Date:
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