

# Direct Deposit Authorization Form

## Healthcare/Dependent Care Reimbursement Account



**SEND COMPLETED FORM TO:**

Meritain Health  
P.O. Box 30111  
Lansing, MI 48909

LOCAL FAX: 517.381.6600  
FAX: 888.837.3725  
CUSTOMER SERVICE: 800.748.0003

To be reimbursed directly into your bank account from your Flexible Spending Account please complete this form and mail or fax it to the address on the right.

<i>Type of Request</i>	New <input type="checkbox"/>	Change <input type="checkbox"/>	Cancellation <input type="checkbox"/>
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<b>Employee Information</b>	Employer: <b>Michigan State University</b>	Social Security Number
Name: (last, first, initial)		Work Phone: (        )
Address:		Home Phone: (        )
City:	State:	Zip code
Email Address:		

<b>Financial Information</b>	Name(s) on the account:		
Bank or Financial Institution:			Routing/Transit Number
Address:			Account Number
City:	State:	Zip code	Checking Account <input type="checkbox"/> Savings Account* <input type="checkbox"/>

**Voided Check (for checking Account) or Deposit Slip (for Savings Account\*) ~ This is required ~**  
*Please place directly below*

**Terms and Conditions**

1. You must complete, sign, and date this authorization form to enroll in the Direct Deposit Program. If you have a joint account, the form must be signed by both parties. Once your form is received by Meritain Health, there may be up to a four week period before the direct deposit becomes effective. Any claims paid during this time will be mailed to you as a check.
2. In order to take advantage of the Direct Deposit program, your financial institution must be a member of an Automated Clearing House (ACH).
3. You will receive a direct deposit statement each time an electronic transfer is made to your account. The statement will indicate what claims are paid, as well as year-to-date information on your reimbursement account. It can take up to 72 hours for a payment to post into your account after Meritain Health transmits the funds. **Please verify that the deposit has been made into your account before attempting to withdraw funds.**
4. It is your responsibility to notify Meritain Health of any changes to your bank account, such as a closure, or a change in the account number. Complete this form with the new information, and check the change box. There may be up to a four (4) week processing period before the change becomes effective. During this time, you will receive checks for any reimbursement claims paid.
5. You may cancel direct deposit at any time by completing this form and checking the cancellation box. This will take effect as soon as the form is received and processed by Meritain Health.
6. If a direct deposit is returned to Meritain Health, or for any reason cannot be made to your account, Meritain Health will investigate the cause and if needed, issue a reimbursement check. Until the problem is corrected, you will continue to receive checks for any reimbursement claims paid.
7. Direct deposit services will remain in effect from one plan year to the next unless you cancel the direct deposit services.
8. Meritain Health reserves the right to automatically cancel your direct deposit services upon termination of employment or termination of the your reimbursement account.

Questions? Please call Meritain Health at (800) 748-0003.

\* If the savings deposit slip does not contain a routing number maintained by your bank, you will need to submit a bank form, or statement on bank letterhead that verifies the account and routing numbers of your savings account.

### Employee / Account Holder Certification

I certify that I have read and understand the Terms and Conditions on this form. By signing here, I authorize my health reimbursement or flexible spending account reimbursements to be sent to the financial institution and account designated above. This authorization is to remain in effect until Meritain Health has been given a reasonable amount of time to act on written notification from me to terminate the deposits and continue reimbursements with mailed checks.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Joint Account Holder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Any Joint Account Holder MUST sign this form in order to be reimbursed.