

HRA/FSA Direct Deposit Authorization Form

EMPLOYER: _____ GROUP #: _____

LAST NAME: _____ FIRST NAME, MI _____ ID #: _____

EMAIL ADDRESS (REQUIRED): _____

(You will receive your Direct Deposit notification via email, if you do not provide an email address you will only be able to view your account activity on the member portal of www.cbsainc.com/coventry. You will not receive a paper notification.)

You can setup your HRA and/or FSA to directly reimburse your bank account instead of receiving a paper check. In order to enable Direct Deposit of your HRA and FSA disbursements, complete the information below. Remember you can elect different accounts for your HRA and FSA disbursements and you can change your Direct Deposit elections at any time while effective.

DIRECT DEPOSIT of HRA (Health Reimbursement Arrangement) Disbursements

I hereby authorize CBSA Inc., its affiliates and subcontractors acting on behalf of the HRA, to initiate credit entries for HRA disbursements to my deposit account indicated below ("My Account"), and to initiate, if necessary, debit entries and appropriate adjustments for any credit entries to My Account at the financial institution named below, hereinafter called BANK to credit and/or debit the same to My Account.

INITIAL REQUEST CHANGE OF INFORMATION

BANK NAME _____ TYPE OF ACCOUNT: CHECKING SAVINGS

ROUTING NUMBER _____ ACCOUNT NO _____

NAME ON ACCOUNT _____

STAPLE VOIDED CHECK OR DEPOSIT SLIP HERE

DIRECT DEPOSIT of FSA (Flexible Spending Accounts: Healthcare and Dependent Care) Disbursements

I hereby authorize CBSA Inc., its affiliates and subcontractors acting on behalf of the FSA, to initiate credit entries for FSA disbursements to my deposit account indicated below ("My Account"), and to initiate, if necessary, debit entries and appropriate adjustments for any credit entries to My Account at the financial institution named below, hereinafter called BANK to credit and/or debit the same to My Account.

INITIAL REQUEST CHANGE OF INFORMATION

CHECK IF BANKING INFORMATION IS THE SAME AS ABOVE

BANK NAME _____ TYPE OF ACCOUNT: CHECKING SAVINGS

ROUTING NUMBER _____ ACCOUNT NO _____

NAME ON ACCOUNT _____

STAPLE VOIDED CHECK OR DEPOSIT SLIP HERE

This authorization will remain in full force and effect until the Health Plan has received written notification from me of its termination in such time and in such manner as to afford the Health Plan and the Bank a reasonable opportunity to act on it.

Employee Signature: _____ Date: ____/____/____

Print Name: _____

Mail your completed form to:

Coventry FlexChoice/Health Assurance FlexChoice, PO Box 270520, Golden Valley, MN 55427

