

**Mail to:**  
 ASIFlex  
 P.O. Box 6044  
 Columbia, MO 65203  
 (800) 659-3035



**FSA Direct Deposit**  
 Authorization Form

**Fax to:**  
 ASIFlex  
 (866) 381-9682  
 \*No Cover Page Required\*  
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\*Please note that it is not necessary to fill out a form if you have done so in the past, unless you are requesting a change of account information or you are requesting to cancel your direct deposit agreement. You are not required to submit a new form each plan year.

|   |               |  |  |
|---|---------------|--|--|
| <b>Name of Employer:</b>  |               | <b>Social Security Number or Employee I.D. Number:</b>                                       |  |
| <b>Last Name:</b>   |               | <b>First Name:</b>   |  |
| <b>Street Address:</b>  |               |  |  |
| <b>City:</b>  | <b>State:</b> | <b>Zip Code:</b>   |  |
| <b>Daytime Phone Number and Extension:</b>  |               | <b>Email Address:</b>  |  |
| <b>Please indicate the type of agreement being authorized by placing an "x" next to the appropriate field:</b><br><input type="checkbox"/> New Authorization <input type="checkbox"/> Change of Account Information <input type="checkbox"/> Cancel Authorization |               |  |  |
| <b>Bank Name</b>  |               | <b>Nine Digit Routing Number</b>   |  |
| <b>Account Number</b>   |               | <b>Type of Account</b><br><input type="checkbox"/> Checking <input type="checkbox"/> Savings |  |

I wish to receive my FSA reimbursements by Direct Deposit and, by including my email address, I acknowledge that all correspondence regarding account balances and reimbursements will be made electronically. I hereby authorize ASIFlex to originate electronic credit transactions to my bank (or credit union or savings & loan) account indicated below and to credit the same to such account. If necessary, ASIFlex may make deductions from my account for any payments credited to my account in error. This authority is to remain in full force and effect until ASIFlex has received written notification from me of its termination in such time as to afford ASIFlex and my bank a reasonable opportunity to act. **I understand that claims submitted with change will be delayed two business days while ASIFlex completes a zero dollar transaction with my financial institution to confirm the validity of this account.**

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

**Please attach a copy of a voided check, when available. Please do not send a deposit slip as sometimes the routing numbers are different from that of your checks. (Please include a copy of your voided check in the space below)**

**JAMES C. MORRISON**  
 1765 SHERIDAN DR.  
 YOUR CITY, U.S.A. 04093

141  
80-1847/865

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ DOLLARS

Bank Name \_\_\_\_\_  
 Bank Address \_\_\_\_\_

MEMO \_\_\_\_\_ **SAMPLE VOID**

⑆086518477⑆ 0141 ⑈00000000⑈

**Bank Routing or ABA number:** will have symbols on each side and is always nine digits long with a 0, 1, 2, or 3.

**Check number,** usually 4-5 digits. Will also appear in upper right corner of the check.

**Your account number.** Will have symbol on at least one side. Can be up to 17 digits. **NOTE:** Check number may appear with the account number field or to the right of the account number.