



Direct Deposit Application Form

Employer Name

Employee Name (Please type or print)

Social Security #

Daytime Telephone #

NOTE: Account changes must be received two weeks prior to the date the change is effective. Changes received after this date may result in a check issued for reimbursement submitted. If changing accounts, please verify the deposit to the new account before closing the old account. **(IMPORTANT: Complete entire form even if only making a change.)**

Please complete this form and send to HealthSmart Benefit Solutions.

CHECKING ACCOUNT: Attach a **voided check** and record the transit number for that account on this form. It is a 9-digit number that appears at the bottom left of your check between the markings | : |; (Transit number cannot begin with "5.") If you are not sure which number to use, contact your financial institution for assistance prior to submitting this form.

SAVINGS ACCOUNT: Attach a **savings deposit slip** and record the transit number for that account on this form. It is a 9-digit issued by your financial institution. (Transit number cannot begin with "5.") If you are not sure which number to use, contact your financial institution for assistance prior to submitting this form.

MONEY MARKET ACCOUNT: This is a type of checking account. Record a 9-digit transit number issued by your financial institution, and the money market account on this form. (Transit number cannot begin with "5.") **Please confirm these numbers with your financial institution prior to submitting this form.**

Account Information

Action: New Account **Account Type:** Checking
 Change/Correct Account Savings
 Cancel Direct Deposit Money Market

Effective Date _____

Bank Name and Address _____

Routing # (9 digits) _____ Account # _____

The entire balance of each reimbursement will be deposited into the account designated above.

Authorization Agreement: I hereby authorize HealthSmart Benefit Solutions to deposit my reimbursement direct into the account named above. This authority will remain in force until I have given written notice that I have terminated it, or until my employer has notified me that this deposit services has been terminated. I understand that I must give advance notice to allow responsible time for my instructions to be executed. If ever an incorrect amount should be entered into my account, I authorize my bank to make the appropriate adjustment(s).

Employee Signature _____ Date _____

**Please attach a voided check (Checking) or savings deposit slip (Savings)
Send this form to HealthSmart Benefit Solutions, PO Box 71489, Newnan, GA 30271-1489 or Fax to (877)587-4434**