Authorization Agreement for Direct Deposit

I hereby authorize Benefit Administration Company to initiate deposits to the bank account indicated below. I authorize credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. I understand that it is my responsibility to verify that payments have been credited to my account(s) and that if I fail to provide complete and accurate information, the processing of my request may be delayed or my payments may be erroneously transferred electronically.

Employer: ______________________________

Daytime Phone Number: ______________________________

Email Address: ______________________________

This account is: ❒ New ❒ Change ❒ Cancel

______________	______________	______________
Transit ABA Routing #	Account Number	Account Type (Checking/Savings)

Name of Bank: ______________________________

Bank Address: ______________________________

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Bank Phone: ______________________________

______________________________	______________________________
Please print your name	Social Security Number
Signature	Date

PLEASE ATTACH A VOIDED CHECK

DEPOSIT SLIPS DO NOT ALWAYS HAVE THE CORRECT TRANSIT ABA ROUTING#.

RETURN THIS COMPLETED AND SIGNED AGREEMENT ALONG WITH A CANCELLED CHECK TO:

BENEFIT ADMINISTRATION COMPANY
P.O. BOX 550
SEATTLE, WA 98111-0550
Fax: (206) 682-8016

Entered ______________
Date ______________
Reviewed ______________
Date ______________