DIRECT DEPOSIT APPLICATION

COMPLETE PARTICIPANT INFORMATION (Please Print)

Employer Name: _____

Employee Name: _____ Social Security Number: _____

Address: _____

Telephone Number: _____ Email Address (optional): _____

CHECK BOX FOR NEW ACCOUNT / CHANGE OR CANCEL

☐ NEW ACCOUNT ☐ ACCOUNT CHANGE ☐ CANCEL DIRECT DEPOSIT

CHECK THE ACCOUNT THAT YOU WILL PARTICIPATE IN DIRECT DEPOSIT FOR:

☐ SECTION 105 HEALTH REIMBURSEMENT ARRANGEMENT

COMPLETE THE DIRECT DEPOSIT INFORMATION

I would like my reimbursement amounts to be deposited to the account attached:

Financial Institution: _____

Routing/Transit Number: _____ (Is usually between the ⑆ symbols on your check)

Account Number: _____ (Is usually before the ⑈ symbol on your check)

☐ **CHECKING (Attach a voided or cancelled check)** ☐ **SAVINGS**

Please DO NOT attach a deposit slip! Most deposit slips have the bank's *internal* routing number. Please obtain the proper routing number from your financial institution.

PLEASE READ THE TERMS AND SIGN BELOW

I hereby authorize Diversified Benefit Services, Inc. to reimburse amounts owed to me by initiating credit entries to my account at the financial institution indicated above. Additionally, I hereby authorize the financial institution to accept and to credit any credit entries indicated by Diversified Benefit Services, Inc. to my account. I acknowledge and agree that in the event that Diversified Benefit Services, Inc. deposits or credits funds incorrectly into my account, and/or in the case of an overpayment (fraudulent, inadvertent or otherwise), I authorize my employer to debit my account for an amount not to exceed the original amounts of the incorrect credit. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor. To expedite the process, I request that Diversified Benefit Services, Inc. (hereinafter DBS, Inc.) directly deposit my reimbursement amounts into my financial institution account. I understand that DBS Inc. is responsible for the successful transaction of funds into my account. I agree to hold DBS, Inc. harmless from loss and to indemnify DBS, Inc., limited to the amount of the deposit.

Any dispute arising out of or in connection with this agreement; if not resolved through other methods, shall be determined in accordance with the laws of the State of Wisconsin.

This authorization is to remain in full force and effect until my employer and financial institution have received written notice from me of its termination. The written notice shall be delivered in such a manner as to afford my employer and financial institution a reasonable time to effect the change.

Employee Signature: _____ Date: _____/_____/_____

DIVERSIFIED BENEFIT SERVICES, INC.

Dedicated to Excellence in Benefit Management Solutions

P.O. Box 260, Hartland, WI 53029 (262) 367-3300 . TOLL FREE (800) 234-1229 . FAX: (262) 367-5938 . www.dbsbenefits.com

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