

Health Reimbursement Account Direct Deposit Enrollment Form

To enroll in the Direct Deposit Reimbursement for your Health Reimbursement Account, please complete the form below and return to Alliance Insurance Group, LLC. Please attach a VOIDED Check (a deposit slip is not acceptable) for the account into which the reimbursement will be deposited. All information must be supplied in order for the direct deposit to be established.

I hereby authorize Alliance Insurance Group, LLC to deposit any amounts submitted by eligible receipts for reimbursement from my Health Reimbursement Account directly into the account designated on this form. Furthermore, I authorize my bank to accept and credit any credit entries indicated by Alliance Insurance Group, LLC to my account. In the event that Alliance Insurance Group, LLC deposits funds erroneously into my account, I understand that I will reimburse Alliance Insurance Group, LLC or my employer for these funds.

This authorization is to remain in full force and effect until Alliance Insurance Group, LLC has received updated banking information from me to include date of change and signature authorizing the change. Termination of employment also terminates this agreement.

Employer Name: _____

Employee Name: _____ Social Security #: _____

Employee Email Address: _____

Employee Signature: _____ Date: _____

Account Information

Checking Account Bank Name: _____
Routing Number: _____ Account Number: _____

Savings Account Bank Name: _____
Routing Number: _____ Account Number: _____

ATTACH VOIDED CHECK: