



Direct Deposit Authorization Request

HRA and/or FSA Owner Information:

Employer Name: _____			
Employee Name: _____		Social Security #: _____	
Street Address: _____		City: _____	State: _____ Zip: _____
Date of Birth: _____	Phone # _____	Email Address: _____	

Account to Credit (Please attach a voided check):

Financial Institution Name: _____	
Financial Institution Address: _____	
Financial Institution City, State, Zip: _____	
Routing # (9 digits): _____	Account #: _____
Please select One: <input type="checkbox"/> Checking Account	
<input type="checkbox"/> Savings Account	

Transaction Amount and Date:

Start After Date: ____/____/____	Amount of Deposit: _____
<input type="checkbox"/> Weekly (circle day if applicable):	Monday Tuesday Wednesday Thursday Friday
<input type="checkbox"/> Monthly : Date of Month _____	

Signature & Authorization:

I hereby authorize London Health Administrators to initiate direct deposits into my checking/savings account(s) at the financial institution stated above. This authorization is to remain active until London Health Administrators receives written notification from me in such time and in such manner as to afford London Health Administrators a reasonable opportunity to act on it. I acknowledge that I am the owner of the bank account(s) entered in this form.	
Signature of Account Holder: _____	Date of Application: _____

** Please attach a voided check when returning this form to London Health Administrators*