London Health Administrators
Health Care Saving Solutions

Please Send Completed Form To:
London Health Administrators
40 Commercial Way, East Providence, RI 02914
Email: customerservice@londonhealthusa.com
Fax: 401-435-3937
Questions, please call 401-435-4700

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: ☐ Checking Account ☐ Savings Account

Transaction Amount and Date:

Start After Date:_____/_____/____ Amount of Deposit:_____

☐ Weekly (circle day if applicable): Monday Tuesday Wednesday Thursday Friday

☐ 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*