HealthTrust

FLEXIBLE SPENDING ACCOUNT

Direct Deposit Authorization Form

Employee Name:_____

Mailing Address: _____

Employer: _____

BANKING INFORMATION

Bank or Credit Union Name: _____

Address: _____

City/State/Zip: _____

Account Type: ❑ Checking Account ❑ Savings Account

Routing Number (9 digits): | | | | | | | | | |

Account Number:_____

*(Please attach a copy of a **voided check** for checking accounts OR **savings deposit slip** for savings accounts.)*

I hereby authorize HealthTrust to make payment of any Flexible Spending Account (FSA) claim(s) as a Direct Deposit to the financial institution indicated above. I also authorize HealthTrust to debit my account to recover any mistaken payments. This authorization will remain in force until HealthTrust has received written notification from me of its termination or my participation in the FSA program through HealthTrust has ended.

Signature:_____ **Date:** _____

Mail to: HealthTrust
PO Box 617
Concord, NH 03302-0617
Attention: FSA Dept.

or

FAX to: 603.415.3099