

EMPLOYEE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS

EMPLOYER'S NAME _____

I (we) hereby authorize Benefit Extras, Inc., hereinafter called COMPANY, to initiate credit entries to the account indicated below at the named depository financial institution hereafter called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Bank Name _____ Branch _____

City _____ State _____ Zip _____

Routing Account
Number _____ Number _____

Checking Account / Savings Account

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

EMPLOYEE'S NAME _____

(Please Print)

Date _____ Signature _____

I wish to cancel Direct Deposit

NOTE: WRITTEN CREDIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

Please send or fax completed form along with a copy of a voided check or savings deposit slip to:

**Benefit Extras
PO Box 1815
Burnsville, MN 55337
Fax: (952) 435-8435**

(Please retain a copy for your records)

It does take approximately 12-14 days once Benefit Extras receives this form until the direct deposit becomes effective.

Any claims submitted prior to it being in effect will be paid via check.