DIVERSIFIED BENEFIT SERVICES, INC.

Excellence in Benefit Management Solutions

# Direct Deposit Application

## Participant Information (please print):

Employer Name: _____

Participant Name: _____ Last Four Digits of SS#: ☐☐☐☐

Participant Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

## Check Box for New Account/Change/Cancel (please select one):

☐ New Account ☐ Change Account ☐ Cancel Direct Deposit

## Participant Banking Information:

I would like my Health Reimbursement Arrangement (HRA) reimbursements to be deposited to the account listed below:

Financial Institution: _____

Routing # (nine digits): _____ (is usually between the ⑆ symbols on your check)

Account #: _____ (is usually between the ⑈ symbols on your check) Account Type:

☐ Checking (attach a voided or cancelled check)

☐ Savings (Please DO NOT attach a deposit slip. Most deposit slips have the bank's *internal* routing number. Please obtain the proper routing number from your financial institution.)

## Please Read the Terms and Sign Below

I hereby authorize Diversified Benefit Services, Inc. (DBS) to reimburse amounts owed to me by initiating credit entries to my account at the financial institution listed above. Additionally, I hereby authorize the financial institution to accept and to credit any credit entries initiated by DBS to my account. I acknowledge and agree that in the event DBS deposits or credits funds incorrectly to my account, and/or in the case of an overpayment (fraudulent, inadvertent, or otherwise), I authorize my employer to debit my account for an amount not to exceed the original amount of the incorrect credit. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor. I understand that DBS is responsible for the successful transaction of funds into my account. I agree to hold DBS harmless from loss and to indemnify DBS, limited to the amount of the deposit.

Any dispute arising out of or in connection with this agreement, if not resolved through other methods, shall be determined in accordance with the laws of the State of Wisconsin.

This authorization is to remain in full force and effect until my employer and financial institution have received written notice from me of its termination. The written notice shall be delivered in such a manner as to afford my employer and financial institution reasonable time to implement the change.

**Participant Signature:** _____ **Date:** _____

Diversified Benefit Services, Inc.
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