AUTHORIZATION FOR DIRECT DEPOSIT (EFT) CLAIMS/DISTRIBUTION PROCESSING

(PLEASE PRINT)

Instructions – This form is used to sign up for direct deposit for any non-debit card claims distributions from your MyHSA account. When you submit a manual claim Alliance Benefit Group of IL will remove the money from your MyHSA account and electronically transfer the funds to the bank account you provide below.

ACCOUNT HOLDER INFORMATION		
Name: (First):	(MI):	(Last):
Social Security Number:	Daytime Phone Number:	
Mailing Address:		
City:	State:	Zip:
Email Address:		

I hereby authorize Alliance Benefit Group (ABG) as program administrator to initiate credit entries as direct deposit claim reimbursements and to initiate, if necessary, debit adjustment entries made for any credit entry made in error to my account. These transactions are made through regional automated clearing house (ACH) associations and are subject to the operating rules and regulations of the National Automated Clearinghouse Association (NACHA).

I understand this change will not be effective until the third business day following receipt of the completed form by Alliance Benefit Group of Illinois. Where applicable, ACH returns will incur additional fees.

Please complete the appropriate sections (for new EFT, complete all):

____
Name of Financial Institution

____
Routing and Transit Number (9 Digits)

____
Account Number *(Authorization applies to checking accounts only)*

I certify that I am the owner of the account named above and that I have the legal right to provide this authorization. This authority shall apply to all requests for claim reimbursements I submit to ABG under the Health Savings Account program. This authorization remains in full force and effect until which time ABG has received written notification from me of its termination. I agree to provide such notification of cancellation in such a manner as to afford Alliance Benefit Group reasonable time to act on it. Failure to notify ABG in a timely manner could result in additional fees.

Signature of Account Holder: __________________________________ **Date:** _____________

****A COPY OF A VOIDED CHECK MUST BE ATTACHED****

MAIL OR FAX A COPY OF THIS FORM TO:
ALLIANCE BENEFIT GROUP OF ILLINOIS
MyHSA DEPARTMENT
456 FULTON STREET, SUITE 345
PEORIA, IL 61602

FAX (800) 688-4329

If you have any questions please call 800-57MyHSA (800-576-9472).