

HEALTH REIMBURSEMENT ARRANGEMENT EMPLOYEE BANKING INFORMATION

The following information is required for your participation in the Beneflex Health Reimbursement Arrangement (HRA) plan. This form must be entirely completed and returned to Beneflex Inc either by mail or fax.

Reimbursement claims for your Health Reimbursement Arrangement are done via Electronic Funds Transfer to expedite reimbursement directly to the bank account of your choice. The information that you provide us remains confidential.

I certify that by signing this agreement, I authorize Beneflex Inc., to initiate credit entries to the account indicated below for the purpose of reimbursing claims from my Health Reimbursement Arrangement account. I also authorize Beneflex Inc., to initiate, if necessary debit entries and adjustments for any credits made in error.

SIGNED: _____ DATE: _____

PERSONAL INFORMATION REQUIRED - PLEASE PRINT

EMPLOYER: _____

YOUR LAST NAME: _____ FIRST NAME: _____ MI _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

E-MAIL: _____

Required for automatic notice of money transferred

YOUR SOCIAL SECURITY NUMBER: [][][] [][] [][][][]

BANKING INFORMATION REQUIRED - PLEASE PRINT

NAME OF BANK: _____

TYPE OF ACCOUNT: CHECKING SAVINGS

ROUTING NUMBER: [][][][][][][][][] (FIRST 9 NUMBERS ON BOTTOM LEFT OF CHECK)

ACCOUNT NUMBER: [][][][][][][][][][][][][][][][][][]

Please fax or mail the completed form to:

BENEFLEX INC.
3354 Perimeter Hill Drive, Suite 112
Nashville, TN 37211