



Direct Deposit Form For Health Flexible Spending Account

Use this form to enable HealthSmart Benefit Solutions to deposit Health Flexible Spending Account (HFSA) reimbursements directly into your account, or to change or cancel your direct deposit arrangement. Please complete the information below.

Please mail/fax completed form to:

HealthSmart Benefit Solutions ■ Financial Services Dept. ■ P.O. Box 3043 ■ Charleston, WV 25332
Toll Free 877.517.6370 or TDD 877.517.6416 ■ Fax: 304.353.8727

Contact Information

Plan Name AlaskaCare	Group Number 05851 Active	Member ID (required)
Name (First, Middle Initial, Last)		
Home Telephone (Include area code)		Work Telephone (Include area code)

As an AlaskaCare Health Flexible Spending Account (HFSA) participant, you may choose to have HFSA reimbursements directly deposited to your bank account. Direct deposit is a faster and more secure method than mailed checks. You will be notified by mail when your claim has been processed and funds have been deposited into your account. With this notice, you will receive the detail of the claim(s) and the amount paid.

Note: Please allow 14 days for direct deposit to be set-up for your account. Once direct deposit is established, all HFSA reimbursements will be processed by this method. If you would like to receive a reimbursement by manual check, you will need to cancel your direct deposit agreement by completing the Direct Deposit Cancellation Request section below.

Direct Deposit Set-up/Account Change/Cancellation Request

(Complete this section to implement new direct deposit service or to change an existing direct deposit account.)

Select One Of The Following:

Set-up Direct Deposit Change Direct Deposit Account Cancel

Select One Of The Following:

Checking Account Savings Account

Effective Date of Action

Bank/C.U. Routing Number (9 digits)

||:| | | | | | | | | |:|

Personal Account Number (As it appears on check)

For changes to your account information please provide the following:

Old Routing Number

Old Account Number

I hereby authorize HealthSmart Benefit Solutions to directly deposit transactions to the account identified above. I understand that the notice of deposit is not a guarantee that funds have been received by my financial institution. I acknowledge that this authorization is binding and may only be altered or cancelled upon written notification from me to HealthSmart Benefit Solutions. A voided check is attached. I understand that a manual check will be mailed to my home address if I elect to cancel my direct deposit agreement with HealthSmart Benefit Solutions.

Authorized Signature For Direct Deposit Implementation/Account Change/Cancellation Request

Member's Signature	Date
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We recommend attaching an original or photocopy of a voided check