10275 W. Higgins Road, Suite 500
Rosemont, IL 60018
888-FLEXHSA - Phone
847-440-9063 - Fax
flexhsa@flexiblebenefit.com - Email
www.flexhsa.com

AUTHORIZATION AGREEMENT FOR AUTOMATIC CONTRIBUTIONS

A ACCOUNT INFORMATION

Account Holder's Name:_____ Account Number:_____

Social Security No.:_____

B AUTHORIZATION FOR AUTOMATIC CONTRIBUTIONS

You may elect to have Automatic Contributions deposited into your HSA account by filling out the following information:

I wish to make the following contribution to my HSA beginning _____

Please indicate the frequency and amount below:

- □ Monthly contribution of $ _____ on the □ 1st or □ 15th

Please indicate the :

- □ Checking Account No.: _____
- □ Savings Account No.: _____

Bank Name:_____

Routing No. (*must be 9 digits in length*):__ __ __ __ __ __ __ __ __ Bank Telephone No.:_____

This authorization is to remain in full force and effect until FlexHSA has received written notification from you of its termination or changes to information contained herein. I agree to notify FlexHSA in writing at least thirty (30) days in advance to cancel this EFT-ACH funding.

C ACCOUNT HOLDER'S ACKNOWLEDGEMENT AND SIGNATURE

FlexHSA is authorized to credit my HSA account for the amount of the contribution when received, and to debit my account for any fees due for this service. I agree that I am responsible to insure that the amount listed above is in my bank account and that all fees associated with this transaction are also my responsibility. I understand that FlexHSA may reverse previous transactions in my account to be reimbursed for all amounts owing. I further agree that FlexHSA will bear no responsibility for any action or inaction due to insufficient balances. I further agree to pay any fees normally charged by FlexHSA for this service.

Unless informed otherwise, FlexHSA will assign any contribution received to the tax reporting year in which it is received. I am responsible for calculating the proper contribution limitations to avoid excess contributions. I understand that it is my responsibility for excess contribution calculation fees and any penalties that may apply.

I agree that FlexHSA may discontinue this service at any time, and that I am responsible for supplying to FlexHSA accurate information concerning my Depository, including the bank routing/transit/ABA number, and my account number and type, and any changes to this information which may occur in the future. FlexHSA bears no responsibility and assumes no liability for the accuracy of or changes to this information.

Account Holder's Signature: _____ Date: _____

Please return all forms to the above address, Attn: FlexHSA Processing.