

# Retiree Health Reimbursement Plan Direct Deposit Authorization

Your Company Name/Plan Name: \_\_\_\_\_  
(Must be completed for your claim to be processed.)

Please complete this form to have your RHRP reimbursements automatically deposited into either your checking or savings account. Please note that in order to establish the Direct Deposit service, you will need to provide a valid e-mail address. Also, it may take up to 2 weeks to establish Direct Deposit. A check will be mailed until setup is complete.

If you have any questions about your account status, please contact us at [www.acclarisonline.com](http://www.acclarisonline.com) virtually 24 hours a day, 7 days a week or call the Acclaris Reimbursement Center toll-free at 1-866-203-9358, Monday through Friday (excluding New York Stock Exchange holidays) between 8:00 A.M. and 8:00 P.M. Eastern Standard Time to speak with a Customer Service Representative.

**You must sign and date this form to authorize your direct deposit request.**

After you complete this form, please make a copy for your files and return the original together with a voided check (for checking accounts) and fax or mail to:

**Fax: 1-813-849-6570**  
**Acclaris Reimbursement Center**  
**P.O. Box 25171**  
**Lehigh Valley, 18002-5171**

## Direct Deposit Election

1. <b>Election Type:</b> (check only one box)	<input type="checkbox"/> <b>New Election</b> <i>Note: You are <b>not</b> required to submit a new form each plan year.</i>	<input type="checkbox"/> <b>Change an Existing Election</b>	<input type="checkbox"/> <b>Cancel an Existing Election</b>
2. <b>Account Type:</b> (check only one box)	<input type="checkbox"/> <b>Checking</b>	<input type="checkbox"/> <b>Savings</b>	
3. <b>Account Information</b>			
<b>Financial Institution Name:</b> _____		<b>Branch Address:</b> _____	
<b>Routing #:</b> _____		<b>Account #:</b> _____	
<i>Routing numbers are always 9 digits</i>			
<b>For checking accounts</b> , attach your voided check to the bottom of this form. If you attach a voided check you do not need to fill in the routing and account numbers requested above. <b>Note:</b> Do not send in a deposit slip; deposit slips may not contain the required information.			
<b>For savings accounts</b> , call your financial institution to obtain the routing and account numbers. Or you may ask them to send you a document with this information, which you can then attach to this form before sending it to the Acclaris Reimbursement Center. <b>Note:</b> Do not send in a deposit slip; deposit slips may not contain the required information.			

## Your Authorization and Date

I authorize Acclaris to electronically deposit entries to my financial institution (as indicated above) for reimbursements from my account. I further authorize Acclaris to process changes (debit and credit entries) to my account to adjust for any errors related to such entries. I understand that Acclaris is NOT responsible if my financial institution does not make funds immediately available at the time of transmission and is not responsible or liable for any errors or disputes arising from my relationship with my financial institution. I further understand that I may terminate or change this agreement by written notification to Acclaris or by editing my direct deposit account information in my online account with Acclaris. Any such change or notification will be effective only after Acclaris has had reasonable time to act on it.

Signing this form acknowledges your understanding and agreement with the above statements.

**Signature of Participant:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Please print the information below.)

Name: \_\_\_\_\_ Daytime Phone No.: ( ) \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_