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##19T01415##########

DIRECT DEPOSIT AUTHORIZATION

NAME: _____

TRIBE: _____

Tribal Roll Number:	**Email Address:**	**Daytime Phone:**

Mailing Address:

NOTE: THIS INFORMATION CARRIES FORWARD FROM YEAR TO YEAR. IF A FORM IS ON FILE WITH FSA TPA, IT IS NOT NECESSARY TO SEND IN A NEW FORM EACH PLAN YEAR.

☐ **START:** I hereby authorize and request the payment of all future Tribal Benefit Program claims be by direct deposit to my account below. I understand it may take up to 10 days for the change to be effective.

☐ **STOP:** I hereby authorize and request the payment of all future Tribal Benefit Program claims be by check and mailed to my address of record on file with FSA TPA.

☐ **CHANGE ACCOUNTS:** I hereby authorize and request the payment of all Tribal Benefit Program claims be by direct deposit to the new account below. I understand it may take up to 10 days for the change to be effective.

Financial Institution: _____

*(Netspend, Net Pay and Chime Bank **NOT** accepted; GreenDot Bank preferred pre-paid solution)*

Account Type: ☐ Checking ☐ Savings

Account Number:

Routing Number:

ATTACH COPY OF VOIDED CHECK

OR

LETTER FROM BANK WITH ACCOUNT INFORMATION

(Please No Deposit Slip)

Policies of Direct Deposit:

- Participants have the opportunity to receive their claim reimbursement by direct deposit into their checking or savings account or by check via USPS mail. If no election is made by a Participant, a check will be mailed directly to the address of record on file with FSA TPA.
- If a direct deposit is requested, notification of payment will be sent to the email on file. Participants may view their account activity on our website (fsatpa.com).
- Participants requesting direct deposit must provide, or have previously provided, an election for direct deposit and a voided check.
- I hereby authorize FSA TPA to deposit any amounts submitted by eligible receipts for reimbursement from my Benefit Account directly into the account designated on this form. Furthermore, I authorize my bank to accept and to credit any credit entries indicated by FSA TPA to my account. In the event that FSA TPA deposits funds erroneously into my account, I authorize FSA TPA to debit my account for an amount not to exceed the original amount of the erroneous credit.
- This authorization is to remain in full force and effect until FSA TPA and the bank have received written notice from me of its termination in such time and in such manner as to afford FSA TPA and the bank reasonable opportunity to act on such notice.

_____ _____

Participant Signature **Date**