

## **AUTHORIZATION FOR DIRECT DEPOSIT**

I authorize Core Benefits, Inc. through Echo Health Inc. to directly deposit all health, dental, vision, and flexible spending funds directly into my bank account as follows:

Bank name:

Bank account number:
Bank routing number:
Type of account: checking or savings (Attach deposit slip or voided check)
I understand that this will be in effect until such time as I notify Core Benefits, Inc. in writing to terminate it and understand that it will take 7 business days to make this change.
I also understand that if I provide an email address below that all notifications will be made to that email address instead of the mail.
Group Name:
Group Number:
Name:
Social Security number:
Email address: (if blank, notifications will be sent via mail)
Signature: Date: