CONSOCIATE HEALTH

Consociate Direct Deposit Authorization

Please complete & return to Consociate via email, fax, or mail. Direct deposit will become effective within 2 weeks from the date of receipt.

I hereby authorize Consociate to initiate credit entries or debit entries to correct errors, depositing my Flexible Spending Account reimbursements into my account designated below and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until Consociate has received written notification from me of its termination in such time and such manner as to afford Consociate reasonable opportunity to act on it. Please check with your financial institution before drawing funds. The funds will **generally** be available within 2 business days after the check date. Consociate is not responsible for overdraft charges.

Employee Name	Employee ID Number	Home Phone	Work Phone

Bank Name	Routing Number	Account Number	Bank Phone

Employer Name

Please Indicate: ○ Initial Set-Up ○ Change ○ Cancel

Please Indicate: ○ Checking Account ○ Savings Account

If you send in this enrollment form and your employer has not enrolled in the direct deposit option, the enrollment form and cancelled check will be destroyed for confidentiality purposes. A new form will have to be submitted if your employer subsequently enrolls in this option.

Employee Signature: _____ Date: _____

For Official Use Only

Effective Date ____/____/____ Processed Date ____/____/____ Processor _____

Please print and retain a copy for your records.

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