

**Authorization Agreement
Direct Payments (ACH debits)**

I (we) hereby authorize Health Savings Administrators, herein after called the COMPANY, to debit entries to my (our) account indicated below and the financial institution named below, hereinafter called the FINANCIAL INSTITUTION, to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Financial Institution Name _____ Branch _____

Address _____ City/State _____ ZIP _____

Routing Number _____ Account Number _____

Type of Account: ___ Checking ___ Savings

Monthly Amount \$ _____ Beginning date ____/____/____

Date of Debit (choose one) ___1st of the month ___20th of the month

This authority remains in full force and effect until the COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford the COMPANY and FINANCIAL INSITUTION a reasonable opportunity to act on it.

Print Individual Name _____

Print Individual Name _____

Print Individual ID Number _____

Print Individual ID Number _____

Signature _____

Signature _____

Date _____

Date _____

PLEASE ATTACH A VOIDED CHECK TO THIS FORM
(Customer retains second copy)