



Return Form To:
Nova Healthcare Administrators, Inc.
an Independent Health Company
Attn: FSA Administration
511 Farber Lakes Drive
Buffalo, New York 14221

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Please complete the following information below to set-up direct deposit of manual claim reimbursement into your personal checking/savings account

Section 1 – Employee Information

Employee Name: _____

Social Security Number: _____ Employer: _____

Section 2 – Account Status

☐ New Agreement ☐ Change in Account ☐ Cancel Account

Allow 10 business days to processing of this authorization

Section 3 – Banking Information

Account Type: ☐ Checking ☐ Savings

Bank Name: _____

City: _____ State: _____ Zip: _____

Transit/ABA Number: _____ Bank Account Number: _____

Attach a voided check here to Checking Accounts

or

Attach a deposit slip for Savings Accounts

I hereby authorize Independent Health Corporation to initiate credit entries and if necessary, debit entries and adjustments for any entries made in error to my account as indicated. This authorization will remain in effect until Independent Health Corporation has received written notification from me of its termination in such a manner as to allow Independent Health Corporation reasonable opportunity to act upon it. If I change any account, I will complete a new Authorization Agreement for Direct Deposit listing the new account information. I understand this authorization is for reimbursement for my Flexible Benefits, Health Reimbursement Plan and/or Transportation Benefit Plan. I understand that my deposits may not be credited to my account for up to two business days after the transaction has been sent to the bank for processing.

Employee Signature: _____

Date: _____