



Wellmark Blue Cross Blue Shield of Iowa
Wellmark Blue Cross Blue Shield of South Dakota

Independent Licensees of the Blue Cross and
Blue Shield Association

Reimbursement Account Authorization Agreement for Direct Deposit

Health and Dependent Care Reimbursement Accounts

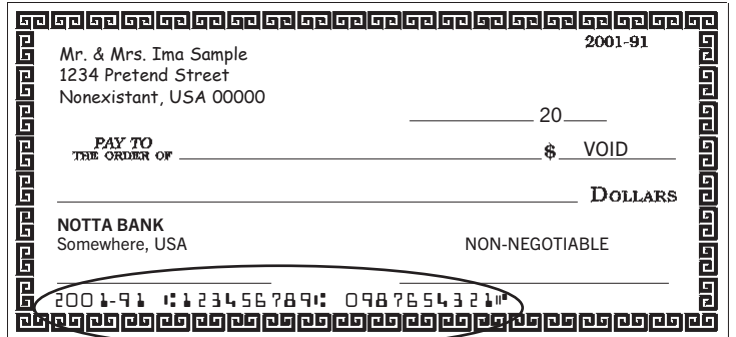
I hereby authorize Wellmark Blue Cross and Blue Shield to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to the account identified below. This election shall remain in force until revoked by me.

This agreement is: New Change Cancel

Account Number: _____

Transit ABA Routing #: _____

- The **Transit ABA Routing #** includes all of the numbers before the colon in the middle of the number. Be sure to include any zeroes at the beginning or end.
- The **Account Number** includes all of the numbers after the colon in the middle of the number. Be sure to include any zeroes at the beginning or end.



Account Type: Checking Savings

Name of Bank: _____ Bank Phone: _____

If you are requesting direct deposit, you must attach a voided check for verification and reference. For any requests other than the beginning of your plan year, it will take two check cycles for the automatic deposit authorization to be processed.

Signature: _____ Date: ____/____/____

Printed Name: _____ Social Security #: _____

Employer Name: _____ Daytime Phone Number: _____

Complete, sign and send this form and a voided check for new and/or change requests to:

Wellmark Blue Cross and Blue Shield
Spending Accounts Office
PO Box 14314
Lexington, Kentucky 40512-4314
Fax # (855) 299-4389
Email: wellfsa@wellmark.com
www.wellmark.com/flex