# City of Tacoma—45000

## DIRECT DEPOSIT AUTHORIZATION FORM

| | |
|---|---|
| Employee Name: | Social Security #: |
| Telephone No: | Employer: |
| Address, City, State, Zip: | |
| e-mail: | |

***I request my*** Health FSA/HRA/Dependent Care FSA ***reimbursement direct deposit to be placed in the following account(s):***

| Institution | Bank ABA Number | Account Number | Type of Account |
|---|---|---|---|
| | # | # | ☐ Checking ☐ Savings |
| | # | # | ☐ Checking ☐ Savings |

**PLEASE PROVIDE A VOIDED CHECK FOR EACH CHECKING/SAVINGS ACCOUNT LISTED ABOVE. TPSC WILL NOT PROCESS WITHOUT A VOIDED CHECK.**

**DO NOT USE A DEPOSIT SLIP, THE NUMBER COULD BE INVALID!**

I authorize my Health FSA/Health Reimbursement Arrangement/Dependent Care FSA reimbursements to be sent to the financial institution named above to be deposited in the designated account.

In the event funds are deposited erroneously into my bank account, I authorize my Health FSA/Health Reimbursement Arrangement/Dependent Care FSA provider to debit my account(s), not to exceed the original amount of the credit.

I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

| | |
|---|---|
| EMPLOYEE'S SIGNATURE: | DATE: |

Trusteed Plans Service Corporation

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