

Part I Direct Deposit Form				
Employer's Name			Social Security Number	
Employee's Last Name		First Name		(M)
				Home Phone (   )
Mailing Address <input type="checkbox"/>			City	State
			Zip code	

Part II Direct Deposit Information			
I request my Medical and Dependent Care reimbursement (s) to be deposited directly in the following account:			
Institution	Bank ABA Number	Account #	Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings

**Please provide a voided check for the account listed above. We will not be able to process this request without a voided check.  
Do not use a deposit slip, the number could be invalid.**

Part III Direct Deposit Authorization	
I authorize my Medical Reimbursement 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 account, I authorize QVI Risk Solutions, Inc to debit my account not to exceed the original amount of the credit. I understand that all direct deposits are made through the automated clearing house (ACH), and that the funds availability is subject to the terms and limitations of the ACH as well as my financial institution. I also understand that it is my responsibility to check my account for reimbursements.	
Employee Signature:	Date:

<input type="checkbox"/> I do not wish to enroll with direct deposit.	
Employee Signature:	Date