DIRECT DEPOSIT AUTHORIZATION

INSTRUCTIONS: PLEASE COMPLETE THIS FORM AND SUBMIT TO:
BAC – ATTN: ADMINISTRATION DEPT., PO BOX 107, REYNOLDSBURG, OH 43068-0107,
OR FAX TO 614.863.9137, OR EMAIL TO FLEXCLAIMS@BACTPA.COM

A. STATEMENT OF PARTICIPANT: PLEASE ANSWER ALL QUESTIONS FULLY

PARTICIPANT (LAST, FIRST, M.):

SOCIAL SECURITY NUMBER:

HOME ADDRESS: CITY: STATE: ZIP CODE:

PHONE NUMBER:

DATE OF BIRTH (MM/DD/YYYY):

IS THIS A NEW ADDRESS?:
◯ **NO** ◯ **YES**

B. ACTION:

CHOOSE ONE:

◉ **FIRST TIME DIRECT DEPOSIT REQUEST**

◯ **CHANGE TO AN EXISTING DIRECT DEPOSIT AUTHORIZATION**

◯ **WITHDRAWAL OF PRIOR DIRECT DEPOSIT AUTHORIZATION – NOTE BY COMPLETING THIS SECTION YOUR CAFETERIA PLAN REIMBURSEMENTS WILL BEGIN BEING PROCESSED BY PAPER CHECK AND MAILED TO THE ADDRESS SHOWN ABOVE.**

IF MAKING A CHANGE PLEASE MAKE CERTAIN TO ALLOW AN APPROPRIATE TIME FRAME BEFORE TERMINATING THE OLD ACCOUNT. IF NOTIFICATION OF THE CHANGE IS NOT RECEIVED BY BAC PRIOR TO TERMINATING THE ORIGINAL ACCOUNT THE MEMBER MAY EXPERIENCE A DELAY IN PAYMENT UNTIL THE CHANGE TAKES EFFECT.

IMPORTANT NOTE:
PLEASE ALLOW A MINIMUM OF 2 WEEKS FOR PROCESSING OF YOUR INITIAL AND/OR CHANGE IN DIRECT DEPOSIT AUTHORIZATION.

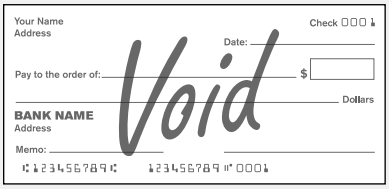
C. ACCOUNT INFO:

TYPE OF ACCOUNT:
◯ **CHECKING** ◯ **SAVINGS**

EMAIL ADDRESS (USER@DOMAIN.COM):

BANK ACCOUNT NUMBER AND ROUTING NUMBER:
◯ **PLEASE ATTACH A VOIDED CHECK**
◯ **IF NO CHECK IS AVAILABLE PLEASE CONFIRM THE ROUTING NUMBER WITH YOUR BANK**

ROUTING NO. _____ **ACCOUNT NO.** _____



PLEASE ATTACH A VOIDED CHECK

E. AUTHORIZATION:

I HEREBY AUTHORIZE BAC TO DIRECTLY DEPOSIT ANY BENEFITS PAYABLE TO ME UNDER MY EMPLOYER SPONSORED CAFETERIA PLAN INTO THE BANK ACCOUNT SHOWN ABOVE. I UNDERSTAND THAT BY SIGNING THIS FORM I GRANT THE PLAN THE RIGHT TO RECOVER/ CORRECT ANY DIRECT DEPOSIT TRANSFER RESULTING FROM AN ERRONEOUS PAYMENT BY DEBITING MY ACCOUNT TO THE EXTENT OF SUCH OVERPAYMENT.

FURTHER, I AGREE NOT TO HOLD BAC RESPONSIBLE FOR ANY DELAY OR LOSS OF FUNDS DUE TO INCORRECT OR INCOMPLETE INFORMATION SUPPLIED BY ME OR BY MY FINANCIAL INSTITUTION OR DUE TO AN ERROR ON THE PART OF MY FINANCIAL INSTITUTION IN DEPOSITING FUNDS TO MY ACCOUNT.

I UNDERSTAND THAT THIS AUTHORIZATION WILL APPLY TO ALL CAFETERIA PLAN ACCOUNTS I AM ENROLLED IN THROUGH BAC. AT THIS TIME THIS AUTHORIZATION DOES NOT APPLY TO MEDICAL, PRESCRIPTION DRUG, DENTAL OR VISION BENEFITS.

THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL WRITTEN REQUEST TO TERMINATE/CHANGE HAS BEEN RECEIVED BY BAC.

X _____
EMPLOYEE'S SIGNATURE

_____
DATE SIGNED (MM/DD/YYYY):

MAIL COMPLETED FORM TO BAC:
ATTN: ADMINISTRATION DEPT.
PO BOX 107 REYNOLDSBURG, OH 43068

OR FAX COMPLETED FORM TO BAC AT:
(614) 863-9137

OR EMAIL COMPLETED FORM TO BAC AT:
FLEXCLAIMS@BACTPA.COM