

**AUTHORIZATION FOR DIRECT DEPOSIT**

**COMPANY NAME**

(PLEASE PRINT)

**EMPLOYEE INFORMATION**

SSN

Last Name

First Name

MI

**ACCOUNT INFORMATION**

Please check one of the following:

- ADD: Deposit my reimbursement funds into the account shown.
- CHANGE: Change my financial institution and/or account number.
- CANCEL - Stop my participation in the direct deposit program.

Type of account:     Checking     Savings

I hereby authorize AXIS Health Partners to initiate deposits to the bank account indicated below. This authority will remain in effect until AXIS has received written notification from me of its termination in a manner that allows AXIS reasonable opportunity to act upon it.

Signature

Date

**ATTACH VOIDED CHECK BELOW**

**Please tape your voided check here.**  
(Do not send deposit slips.)

Please **mail** completed form to AXIS Health Partners at the address below. Allow 10 business days for processing of this authorization. You will receive regular reimbursement checks until this request is processed. Once you agree to the Direct Deposit process, all reimbursement transactions will be in this format until we receive your written request to cancel the process.