



**Authorization Agreement For
ACH Debits/Credits**

I, hereby authorize **AmeriFlex, Inc.**, hereinafter called COMPANY, to initiate debits and/or credits to or from my Bank Account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and or credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error.

I acknowledge that the origination of ACH transactions to or from my account must comply with the provisions of U.S. law. **Please provide copy of VOIDED check.**

Employee Name: _____ Employer Name: _____
Social Security #: _____

Depository Name _____ Account Name _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

Checking Account or Savings Account (Circle One)

This authorization is to remain in full force and effect until COMPANY has received written notification from the employee named above of the termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Authorization _____
(Please Print)

Date _____ Signature _____

PLEASE MAIL OR FAX ORIGINAL TO:

AmeriFlex, LLC
Attn: ACH Department
303 Fellowship Road, Suite 201
Mount Laurel, NJ 08054
Fax # 856-631-1020

Upon receipt, the Federal Reserve requires 14 business days to perform the initial approval of the ACH information. After this time, AmeriFlex will be directly depositing all claim reimbursements into the bank account provided two days after every processing date determined by your employer.

It may take up to 5 business days to have your reimbursements appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. AmeriFlex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.

INDIVIDUAL