ICUBA
FSA/HRA Direct Deposit Form

****** This is an optional payment form******

IMPORTANT! Please Attach a voided check to this form.

Please return form via fax to 866-377-5180, or via US mail to Icuba FSA Administration, P.O. Box 616927 Orlando, FL 32861-6927.

Employee Name _____

Social Security Number __ __ __ - __ __ - __ __ __ __

School _____

Address _____

City, State, Zip _____

Bank Name _____

Account Number _____

Bank ABA # _____

Type of account: **(Check One)**

Checking _____ **Savings** _____

Authorization

I authorize the electronic transfer of funds into the bank account I have specified to reimburse expenses covered by the Spending Account(s) I am enrolled in. This authorization will remain if full effect until I provide written notification of my cancellation or until the end of the plan year.

_____ _____

Employee Signature **Date**

If the account specified is a joint account, the name and signature of the second signor are required to authorize electronic funds transfer to the account.

_____

Name

_____ _____

Signature **Date**