CONTINUON SERVICES

DIRECT DEPOSIT ENROLLMENT FORM

YOU MAY ELECT TO HAVE CLAIM REIMBURSEMENTS DIRECTLY DEPOSITED INTO YOUR BANK ACCOUNT. PLEASE COMPLETE THE FORM BELOW AND RETURN IT TO CONTINUON SERVICES, LLC BY U. S. MAIL OR FAX. ***PLEASE DO NOT E-MAIL THIS FORM TO US.*** *YOU MUST ATTACHED A VOIDED CHECK (A DEPOSIT SLIP IS NOT ACCEPTABLE). PLEASE COMPLETE ALL SECTIONS OF THE FORM. FAILURE TO COMPLETE ALL SECTIONS OF THE FORM WILL DELAY YOUR REQUEST. PLEASE ALLOW 1-2 BUSINESS DAYS FOR PROCESSING.*

Personal Information: (Please print)	
Employer Name:	
Employee Name:	
Last 4 digits of SSN:	***FOR YOUR PROTECTION, DO NOT USE YOUR FULL SSN.***

Banking Information			
Bank Name:		**Bank City:**	
Account Type:	--- Checking --- Savings	**Bank State:**	
Routing/ABA Number:		**Account Number:**	

**** ATTACH A VOIDED CHECK ****

EMPLOYEE AUTHORIZATION

I AUTHORIZE CONTINUON SERVICES, LLC TO DEPOSIT INTO THE ACCOUNT DESIGNATED ON THIS FORM ALL ELIGIBLE REIMBURSEMENTS FROM MY MEDICAL AND/OR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT. I AUTHORIZE MY BANK TO ACCEPT AND CREDIT ANY CREDIT ENTRIES AS INSTRUCTED BY CONTINUON SERVICES, LLC. IN THE EVENT THAT CONTINUON SERVICES, LLC DEPOSITS FUNDS ERRONEOUSLY INTO MY ACCOUNT, I AUTHORIZE CONTINUON SERVICES, LLC TO DEBIT MY ACCOUNT FOR AN AMOUNT NOT TO EXCEED THE ORIGINAL AMOUNT OF THE ERRONEOUS CREDIT.

THIS AUTHORIZATION WILL REMAIN IN FULL FORCE AND EFFECTIVE UNTIL CONTINUON SERVICES, LLC AND THE BANK HAVE RECEIVED WRITTEN NOTICE FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD CONTINUON SERVICES, LLC AND THE BANK REASONABLE OPPORTUNITY TO ACT UPON SUCH NOTICE.

Employee Signature:	**X**	**Date:**	

If you have any questions, please contact us at: 1-877-747-4141 or fsa@csllc.com

Submit to: Continuon Services, LLC
Attn: FSA Administration
P.O. Box 7127
Atlanta, GA 30357-7127

or

Fax to: 1-866-593-7125