



Employer Name _____

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

Employee Name: _____

Employee Mailing Address: _____

Employee Email Address: _____

Employee Social Security Number: _____

I authorize FlexConnect to initiate electronic credit entries, and if necessary, debit entries and adjustments for any credit entries in error to my account. I understand I will not receive notification of my direct deposits; however I can review this information on line at www.insurancecoordinators.com.

Checking Account or Savings Account

ABA Transit Routing Number

Account Number

Name, Address and Phone Number of Financial Institution

Employee's Signature

Date

These entries will be posted to the above account as part of my participation in the Plan.

Mail Form to: FlexConnect, 55 W. 14th Street, Suite 101 Helena, MT 59601 or Fax to (406) 495-3669

***Attach Copy of Voided Check
Here***