



Benefit Administrators

Electronic Funds Transfer (EFT) Form

Employee Information: *(please print clearly)*

Employer Name _____
Employee Name _____
Employee SSN _____
Tel. No. (Work) _____ (Home) _____
Email Address _____

Bank Information:

- (check one)
- Same account information as last year
 - **NEW** account information – please update from last year
 - I do not want to continue EFT (**sign cancellation below**)

Account Information

Financial Institution Name _____
Name(s) on Account _____
Routing Number _____
Account Number _____
(Please attach a voided check. Deposit slips are not valid)

Type of Account

- (check one) • Checking • Savings

Please select applicable benefit account. **NOTE: YOU CAN SELECT MORE THAN ONE.**

- **Dependent Care Flex**
- **Unreimbursed Medical Flex**

Authorization:

I hereby authorize Insight Benefit Administrators LLC to transfer my Flexible Spending Account Reimbursements to the financial institution listed above.

Date _____ Signed _____

Cancellation:

Date _____ Signed _____

Please notify Insight immediately of a change in your financial institution.

Please email or fax to:

Insight Benefit Administrators LLC
EFT Coordinator
Email: Finance_TPA@insightba.net Fax: (616) 588-7900
Phone: (877) 827-1414 or (616) 588-5340