Insight
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