London Health Administrators, Ltd.

Please Mail Completed Form To:
London Health Administrators
40 Commercial Way
East Providence, RI 02914
Phone: 401.435.4700
Fax 401.435.3937

Direct Deposit Authorization Request

FSA Owner Information

Employer Name:

Employee Name:

Street Address: City: State: Zip:

Date of Birth: Social Security #: Phone #

Account to Credit (Please attach a voided check):

Financial Institution Name:

Financial Institution Address:

Financial Institution City, State, Zip:

Routing # (9 digits): Account #:

Please select One: ☐ Checking Account ☐ Savings Account

Transaction Amount and Date:

Start After Date:_____/_____/____ Amount of Deposit:_____

☐ Weekly (circle day if applicable): Monday Tuesday Wednesday Thursday Friday

☐ Monthly : Date of Month _____

Signature & Authorization:

I hereby authorize London Health Administrators to initiate direct deposits into my checking/savings account(s) at the financial institution above. This authorization is to remain in full force and effect until London Health Administrators receives written notification from me in such time and in such manner as to afford London Health Administrators a reasonable opportunity to act on it. You acknowledge that you are the owner of this account entered in this form.

Signature of Account Holder: **Date of Application:**

_____ _____

** Please attach a voided check when returning this form to London Health Administrators*