



DIRECT DEPOSIT AUTHORIZATION

This form is available for use only if your employer offers direct deposit for your reimbursement account(s) through Crosby Benefit Systems.

Date: ____/____/____

Participant Name (please print): _____

Participant Address: _____
(Street)

(City) (State) (Zip Code)

Work (Daytime) Phone Number: _____

Employer: _____ SSN: _____-_____-_____

Type of Request: New Change

Reimbursement Plan Type: FSA Other _____

I authorize Crosby Benefit Systems to deposit my _____ reimbursement check into my: _____
(Please specify account type)

CHECKING account OR SAVINGS account

Routing/Transit #: Acct #: _____

Signed: _____ Date: ____/____/____

Mail completed form to:
Direct Deposit
Crosby Benefit Systems, Inc.
PO Box 929125
Needham, MA 02492-9125

Fax it to:
617-928-0001

For Admin Use Only: New Account Change

PPlus #: _____ Date Set Up: ____/____/____