MEDICA®

DIRECT DEPOSIT AUTHORIZATION FORM

EMPLOYER:_____ **GROUP #:**_____

NAME: _____ **SOCIAL SECURITY #:**_____

☐ HRA (Health Reimbursement Arrangement ☐ Flexible Spending Account (FSA) Medical or Dependent Care ☐ Health Savings Account (HSA)

You can choose Direct Deposit of your reimbursements. Indicate below appropriate account information for your reimbursements. You can change your Direct Deposit elections at any time effective at the time described below. If you have multiple accounts (HRA and FSA for example), fully complete multiple forms to guarantee proper processing.

☐ ORIGINAL ☐ CHANGE

I hereby authorize Medica, its affiliates and subcontractors acting on behalf of Medica to initiate credit entries to the checking account identified below and to initiate debit entries or adjustments for any credit entry made in error to this same account. In addition, I hereby request and authorize the financial institution named below to accept such entries.

☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT

BANK NAME_____BRANCH_____CITY_____ STATE_____ZIP_____

ROUTING NUMBER ___ ___ ___ ___ ___ ___ ___ ___ ___ ACCOUNT NAME_____ACCOUNT NO_____

For Direct Deposit to a CHECKING ACCOUNT, attach a copy of a voided CHECK here.
For Direct Deposit to a SAVINGS ACCOUNT, attach a copy of a voided DEPOSIT SLIP here AND verify that bank routing number is indicated above.

This authorization will remain in full force and effect until Medica has received written notification from me of its termination in such time and in such manner as to afford Medica and the Bank a reasonable opportunity to act on it.

Employee Signature: _____ Date: _____
Print Name: _____

Mail to:

Medica Direct
PO Box 27877
Minneapolis MN 55427-0877

For questions call: Medica Customer Service: (952) 945-8000 (800) 952-3455 or Hearing Impaired Members with a TTY: (952) 992-3190 (800) 841-6753

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