Direct deposit form

HealthEquity®

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Reimbursement Accounts**
PO Box 14374 Lexington, KY 40512

Fax: 801.999.7829 (cover sheet not required)

Primary account holder information

Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	Last 4 of SSN or HealthEquity ID number REQUIRED	

Banking information

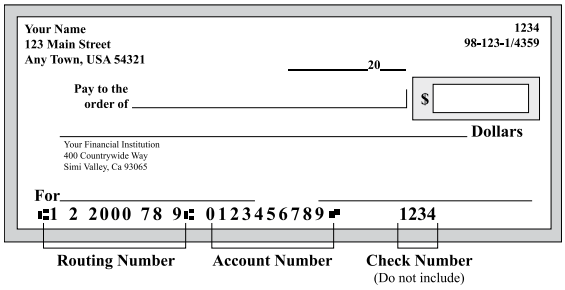
Name on account:_____

Account type: ☐ Checking ☐ Savings

Financial institution:_____

9-digit routing number: _____

Account number: _____



Form must be accompanied by an actual or a copy of a voided check. (Deposit slips are not sufficient)

Note: By choosing direct deposit, no confirmation will be mailed to you. To verify when your last claim was processed, please call Member Services at 877.472.8632. Please contact your bank or credit union to verify receipt of payment in your account. Direct deposit may take up to 2-3 business days to take effect.

Account holder authorization

Account holder signature	Date

Direct deposit cancellation

I choose to cancel my direct deposit agreement with HealthEquity. I understand that any future payments will be sent to my home address via check.

☐ Cancel direct deposit	Effective date
Account holder signature	Date