Associated Benefits Corporation
Electronic Funds Transfer Authorization
Section 125 Cafeteria Plan

Authorization Agreement

I authorize Associated Benefits Corporation to deposit my Cafeteria Plan payments directly into my checking/savings account.

I understand that if I wish to cancel this agreement, or to change banks or accounts, I must notify ABC at least 15 days in advance of the change. I also agree to report any discrepancies to ABC immediately. I agree that all entries made under this agreement shall be governed by the rules of the Mid America Automated Clearing House Association.

If any deposits are made after an event that would cause my payment to stop (for example, employment termination), I authorize and direct ABC on my behalf to refund such deposits to Wells Fargo Bank at the direction of ABC and charge the same account. I agree to indemnify and hold harmless ABC and Wells Fargo Bank from, and against, any and all costs, expenses, losses, judgments, and liabilities of any nature whatsoever as a result of refunding to Wells Fargo Bank any deposits that are made after such an event would cause my payment to stop.

Name _____

Address _____

City, State & Zip _____

SSN _____

Participant Signature _____ Date _____

This is a ☐ Checking account ☐ Savings account.

ATTACH YOUR
VOID CHECK (FOR CHECKING)
OR DEPOSIT SLIP (FOR SAVINGS)
HERE

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