



The Health Care Flexible Spending Account (HCFSA) and the Dependent Care Assistance Program (DeCAP) are divisions of the Office of Labor Relations' Pre-Tax Benefits Program

FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM DIRECT DEPOSIT ENROLLMENT/CHANGE/CANCELLATION FORM



40 Rector Street, 3rd Floor, New York, NY 10006-1705 (212) 306-7760 TTY: (212) 306-7629 nyc.gov/olr

- HCFSA DeCAP HCFSA/DeCAP

TYPE OF ACTION (CHECK ALL THAT APPLY.)

PLEASE ATTACH A VOIDED CHECK OR MOST RECENT SAVINGS STATEMENT.

- INITIAL ENROLLMENT CANCELLATION CHANGE OF NAME ON ACCOUNT
 CHANGE OF ACCOUNT NUMBER CHANGE OF ACCOUNT TYPE CHANGE OF ABA NUMBER

PARTICIPANT INFORMATION (ALL SECTIONS MUST BE COMPLETED.)

Last Name:	First Name:	M.I.:	Social Security Number:
Home Address - Number and Street:	Apt. No.:	City:	State: Zip Code:
Work Phone Number: ()	Home Phone Number: ()		

INITIAL ENROLLMENT/CHANGE

ACCOUNT TYPE: (CHECK ONLY ONE) <input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING	PERSON(S) NAMED ON ACCOUNT (PRINT EXACTLY - INCLUDE TRUSTEE OR JOINT OWNER) PERSON 1: _____ PERSON 2: _____
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ABA NUMBER*	ACCOUNT NUMBER**																													
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*ABA NUMBER: CHECKING ACCOUNT - THE ABA NUMBER IS THE FIRST NINE (9) NUMBERS PRIOR TO THE ACCOUNT NUMBER AT THE BOTTOM LEFT CORNER OF THE CHECK. SAVINGS ACCOUNT - CONTACT YOUR BANK FOR THE ABA NUMBER, IF NOT KNOWN. **ACCOUNT NUMBER: SEE CHECK, PASSBOOK, OR ACCOUNT STATEMENT FOR ACCOUNT NUMBER.

PARTICIPANT AUTHORIZATION

I hereby authorize the Pre-Tax Benefits Program to deposit my HCFSA/DeCAP reimbursement directly into my checking or savings account as requested. I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, the Pre-Tax Benefits Program can only reverse the amount of the incorrect direct deposit. I agree that this authorization will remain in effect until I provide to the Pre-Tax Benefits Program a written cancellation to terminate the service. I will notify the Pre-Tax Benefits Program if my bank account numbers listed above should change.

Participant Signature: _____ Date: _____

CANCELLATION

I hereby authorize the Pre-Tax Benefits Program to cancel my direct deposit agreement.

Participant Signature: _____ Date: _____

Return completed form to: Pre-Tax Benefits Program - FSA Program
 40 Rector Street, 3rd Floor
 New York, NY 10006-1705

Please retain a copy for your records.

DO NOT WRITE IN THIS AREA			
	Database		Agency Payroll Code:
	Initial	Date	
HCFSA			_____
DeCAP			