

DeCAP

Health Care Flexible Spending Account (HCFSA) and the Dependent Care Assistance Program (DeCAP) are divisions of the Office of Labor Relations' Flexible Spending Accounts Program

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



nyc.gov/fsa

☐ HCFSA	□ DeCAP	☐ HCFSA/DeCAP	Plan Yea	ar: 🗆 2024 🗆	2023	Both F	lan Years		
TYPE OF AC	TION (CHECK ALL 1	THAT APPLY)							
☐ Initial Enroll	ment	☐ Change of Name on Account							
☐ Change of A	oe	☐ Char	nge of AE	BA Number					
PARTICIPAN	T INFORMATION	(ALL SECTIONS MUST BE C	OMPLETED)						
SOCIAL SECURITY NUM	MBER	WORK PHONE NUMBER		HOME PHONE NUMBER					
	-			-	-				
LAST NAME				FIRST NAME					MI.
HOME ADDRESS - NUM	MBER AND STREET								APT. NO.
CITY						STATE	ZIP + FOUR	+	
		>-						·	
Account type (CHE	OLLMENT/CHANG	हाड) named on account (PRINT EXACT	IV - INCLUDE TRUCT	EE OR JOINT OWNER) - MU	et attach a vo	idad chac	k or most red	cent cavin	nge etatement
	1)) Hamed on account (PRINT EXACT	LY - INCLUDE TRUST	EE OR JOINT OWNER) - INIU:	si allacii a vo	ided Criec	K OI IIIOSI IEI	Leiil Saviii	igs statement.
□ Checking□ Savings									
ABA NUMBER*	2)	JNT NUMBER**							
ADA NOMBER	Addoct	NI NOMBER							
		HE ABA NUMBER IS THE FIRST N		S PRIOR TO THE ACCO	UNT NUMBER	AT THE BO	TTOM LEFT C	ORNER OF	THE CHECK.
		IK FOR THE ABA NUMBER, IF NOT BOOK, OR ACCOUNT STATEMENT		IIIMDED					
		<u> </u>	TONACCOUNTR	IOMBEN.					
	TAUTHORIZATIO			HOEGA (D. CAD					
		ending Accounts Program grant authorization for the							
understand tha	at, under the "Nation	nal Automated Clearing Ho	ouse Associati	on" operating guide	elines and r	ules, the	Flexible Sp	ending A	Accounts
		ount of the incorrect direct ram a written cancellation							
	numbers listed abov		io tominato ti	o corvios. I will flot	ary trio i loxi	bio opoi	iding / tooot	arito i rog	Ji Carri II Triy
Participant Sig	ınature						Date	/	
CANCELLAT	ION								
I hereby autho	rize the Flexible Sp	ending Accounts Program	to cancel my	direct deposit agre	ement.				
Participant Sig	ınature						Date	1	/
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
			submit form (tps://nyc-fsa.	electronically to: leapfile.net					
			•	for your records.					
DO NOT WRITE	E IN THIS AREA								
	DATABASE								
INITIAL	DATE	AGENCY PAYROLL CODE							
HCFSA									