

**AUTHORIZATION AGREEMENT
PREARRANGED PAYMENTS & DEPOSITS**

I (we) hereby authorize Benefit Administrators, hereinafter called the Plan Service Provider, to initiate credit entries (electronic or otherwise) and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) Health Savings Account and my (our) Personal Bank Account indicated below and the financial institution(s) named below, hereinafter called FINANCIAL INSTITUTION (S), to credit and/or debit the same to such respective accounts.

Also, Plan Service Provider is hereby authorized to initiate debit entries (electronic, draft, check or otherwise), and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) Health Savings Account and my (our) Personal Bank Account indicated below and the financial institution(s) named below, hereinafter called FINANCIAL INSTITUTION (S), to debit and/or credit the same to such respective account.

Personal Bank Account

Name of Financial Institution: _____ Branch: ____
Address, City, State, Zip: _____
Bank Routing Number: _____ Bank Account Number _____
Type of Account: **Checking: _____ Savings: _____

****Attach Voided Check Here!
Deposit slips are not accepted**

HSA Bank Account

Name of Financial Institution: Gateway Bank, F.S.B.
Address, City, State, Zip: 919 Clement Street, San Francisco, CA 94118
Bank Routing Number: 3210-7116-1
Bank Account Number* _____

***YOUR HSA BANK WILL ASSIGN YOUR HSA BANK ACCOUNT NUMBER**

This authority is to remain in full force and effect until the Plan Service Provider has received written notification from me(or either of us) of its termination in such time and manner as to afford Plan Service Provider and Financial Institution a reasonable opportunity to act on it.

Print Your Name: _____ Date: _____

Sign Your Signature: _____ SSN: _____