

Employer HSA Electronic Funds Transfer Form



Mail or fax completed forms to:

Address: HealthEquity, Attn: Client Services
PO Box 14374 Lexington, KY 40512

Fax: 520.844.7090

Authorization for Electronic Funds Transfer

Complete this form if you wish to set up an account to use for electronic funds transfer (EFT) for payments to HealthEquity or for reimbursements from HealthEquity.

Instructions:

1. Complete the Required Employer Information section.
2. Complete the Banking Information section.
3. Submit this form and a copy of a voided check to verify banking information
4. Retain a copy of this form.

Required Employer Information

Employer Name

Tax ID Number

Person Authorizing Transfers

Name (please print)

Signature

Date

Banking Information

Financial institution: _____

9-digit routing number: _____

Account number: _____

Form must be accompanied by a copy of a voided or an actual check.

Your Name 123 Main Street Any Town, USA 54321	1234 98-123-1/4359
Pay to the order of _____	\$ _____ Dollars
Your Financial Institution 400 Countrywide Way Simi Valley, Ca 91065	
For _____	
⑆ 1 2 2000 78 9 ⑆	⑆ 0123456789 ⑆
Routing Number	Account Number
	1234 Check Number (Do not include)

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