



**Request for Electronic Transfer of Claims Payment (Direct Deposit)
Flexible Spending Accounts**

****For paper medical flex claims, paper dependent care account claims, and the
Contract for Dependent Care Account****

Employer Name _____

Group Number _____

Employee Name _____

Employee Social Security Number _____

Effective _____ please direct all Flexible Spending Account
Date Reimbursements to the following bank account:

Checking ** Savings

Financial Institution Name _____

Financial Institution City and State _____

Financial Institution Routing Number _____

Financial Institution Account Number _____

I understand that funds will be directed to this account until a written request is made to
Self Funding Administrators terminating this request.

Signed

Date

****Please provide a copy of a voided check if payments are to be
credited to your checking account.****

Please mail/fax completed form to:

Self Funding Administrators • P.O. Box 6596 • Annapolis, MD 21401
Ph: (410) 757-4200 / (800) 424-8611
Fax: (410) 349-9724