AUTHORIZATION FOR DIRECT DEPOSIT

I authorize Core Benefits, Inc. through Echo Health Inc. to directly deposit all health, dental, vision, and flexible spending funds directly into my bank account as follows:

Bank name: ____

Bank account number: ____

Bank routing number: ____

Type of account: checking or savings (Attach deposit slip or voided check)

I understand that this will be in effect until such time as I notify Core Benefits, Inc. in writing to terminate it and understand that it will take 7 business days to make this change.

I also understand that if I provide an email address below that all notifications will be made to that email address instead of the mail.

Group Name: ____

Group Number: ____

Name: ____

Social Security number: ____

Email address: ____
(if blank, notifications will be sent via mail)

Signature: ____ Date: ____________