

PLACER COUNTY OFFICE OF EDUCATION
125 FLEXIBLE BENEFITS PLAN
AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS

I hereby authorize ENVOY PLAN SERVICES, INC. (ENVOY), to initiate credit entries to my account indicated below, hereinafter called DEPOSITORY, to credit the same to such account in regard to Medical Care and Dependent Care reimbursements of the Placer County Office of Education 125 Flexible Benefits Plan.

This authority is to remain in full force and effect until ENVOY has received written notification of its termination in such time and in such manner as to afford ENVOY and DEPOSITORY a reasonable opportunity to act on it.

DEPOSITORY	
NAME: _____	BRANCH: _____
CITY: _____	STATE: _____ ZIP: _____
TRANSIT/ABA NO.: _____	ACCOUNT NO: _____
NAME(S) ON ACCOUNT: _____	
TYPE OF ACCOUNT: _____	
Checking, Savings, etc.	
SSN NUMBER ON ACCOUNT: _____	
Print exactly as appears on account	
EMAIL ADDRESS: _____	
For notification of deposits	

DATE: _____	SIGNATURE: _____
	Account holder's signature

ATTACH A VOIDED CHECK HERE