DIRECT DEPOSIT AUTHORIZATION FORM

Type of Transaction (Circle One): New Change Cancel

Name of Financial Institution: ____

City, State and Zip code: ____

Account Type (Circle One): Checking Savings

Account Number: _________________________________

Routing Number: _________________________________

These numbers are located on the bottom of your check as follows:

⑆ 123456789 ⑆ 1234567890123 ⑈
Routing Number Account Number

A "Voided" check must accompany this form

Group Name: ______________________________ Group Number: _____________

Employee Name: ___________________________ Employee ID#: _____________

☐ I authorize Lucent Health to initiate a credit and/or debit entry to my financial institution named above for my Flexible Spending Account reimbursements. This agreement remains in effect until written notification is supplied by me terminating this agreement.

Signature: ___________________________________ Date: ________________

Fill out completely and return to:

Lucent Health
PO Box 7020
Appleton WI 54912-7020

Or Fax to: (920) 968-4616
Attn: Finance