DIRECT DEPOSIT AUTHORIZATION FORM

Type of Transaction (Circle One):	New	Change	Cancel

Name of Financial Institution: _____

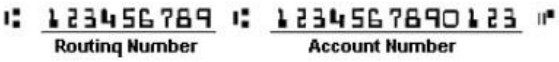
City, State and Zip code: _____

Account Type (Circle One): Checking Savings

Account Number: _____

Routing Number: _____

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



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