



The Health Care Flexible Spending Account (HCFSAs) and the Dependent Care Assistance Program (DeCAP) are divisions of the Office of Labor Relations' Tax-Favored Benefits Program

**FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM
DIRECT DEPOSIT ENROLLMENT/CHANGE/CANCELLATION FORM**

40 Rector Street, 3rd Floor, New York, NY 10006-1705
(212) 306-7760 TTY: (212) 306-7629 nyc.gov/fsa



HCFSAs DeCAP HCFSAs/DeCAP | Plan Year: 2012 2011 Both Plan Years

TYPE OF ACTION (CHECK ALL THAT APPLY)

Initial Enrollment Cancellation Change of Name on Account
 Change of Account Number Change of Account Type Change of ABA Number

PARTICIPANT INFORMATION (ALL SECTIONS MUST BE COMPLETED)

SOCIAL SECURITY NUMBER		WORK PHONE NUMBER		HOME PHONE NUMBER	
LAST NAME		FIRST NAME			MI.
HOME ADDRESS - NUMBER AND STREET					APT. NO.
CITY			STATE	ZIP + FOUR	

INITIAL ENROLLMENT/CHANGE

Account type (CHECK ONLY ONE)	Person(s) named on account (PRINT EXACTLY - INCLUDE TRUSTEE OR JOINT OWNER) - Must attach a voided check or most recent savings statement.
<input type="checkbox"/> Checking	1)
<input type="checkbox"/> Savings	2)
ABA NUMBER*	ACCOUNT NUMBER**

*ABA NUMBER: CHECKING ACCOUNT - THE ABA NUMBER IS THE FIRST NINE (9) NUMBERS PRIOR TO THE ACCOUNT NUMBER AT THE BOTTOM LEFT CORNER OF THE CHECK. SAVINGS ACCOUNT - CONTACT YOUR BANK FOR THE ABA NUMBER, IF NOT KNOWN.

**ACCOUNT NUMBER: SEE CHECK, PASSBOOK, OR ACCOUNT STATEMENT FOR ACCOUNT NUMBER.

PARTICIPANT AUTHORIZATION

I hereby authorize the Tax-Favored Benefits Program to deposit my HCFSAs/DeCAP reimbursement directly into my checking or savings account as requested. I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, the Tax-Favored Benefits Program can only reverse the amount of the incorrect direct deposit. I agree that this authorization will remain in effect until I provide to the Tax-Favored Benefits Program a written cancellation to terminate the service. I will notify the Tax-Favored Benefits Program if my bank account numbers listed above should change.

Participant Signature _____ Date / /

CANCELLATION

I hereby authorize the Tax-Favored Benefits Program to cancel my direct deposit agreement.

Participant Signature _____ Date / /

Return completed Form to:
Tax-Favored Benefits Program - FSA Program
40 Rector Street, 3rd Floor
New York, NY 10006-1705

Please retain a copy for your records.

DO NOT WRITE IN THIS AREA									
DATABASE									
INITIAL		DATE						AGENCY PAYROLL CODE	
HCFSAs				/		/			
DeCAP				/		/			