

Direct deposit authorization



Initiate direct deposit Change account Cancel direct deposit

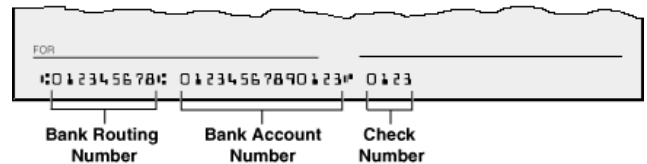
Section 1 > Personal information

| | | | | | |
|------------------|--|-----------|------|-------|----------|
| Employer name | | | | | |
| Member ID no. | | Phone no. | | | |
| Last name | | First | | M.I. | |
| Address/P.O. Box | | | City | State | ZIP code |
| Email address | | | | | |

Section 2 > Financial institution information *Please provide a copy of a voided check.*

| | |
|--------------|--|
| Name of bank | <input type="checkbox"/> Checking <input type="checkbox"/> Savings |
|--------------|--|

| |
|---|
| Routing no. <i>(First 9 digits on the bottom of your check)</i> |
| Account no. |



Section 3 > Authorization

By electing to have my reimbursements directly deposited into my bank account, I understand that:

- All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take three to five (3 – 5) business days to appear in the designated account.
- It is my responsibility to notify Moda Health immediately of any changes in my bank account, such as account closure or change in account number. If there is an interruption in the direct deposit service, I will receive checks for any reimbursement claims paid during that time.

I have read and understand the guidelines stated above. I hereby certify the information on this form is accurate. Further, I understand my completion and submission of this form authorizes Moda Health to issue payment directly to the specified account. I may cancel my participation in the direct deposit program at any time.

| | |
|-------------------------|------|
| Employee signature X | Date |
|-------------------------|------|

Ready to submit? Mail or email this form to:

Mail: Moda Health, 601 S.W. Second Ave., Portland, OR 97204-3156

Fax: 503-243-3959 **Email:** Scan and send to medical@modahealth.com.

Questions? Call us toll-free at 877-605-3229. (TTY users, please dial 711.)

modahealth.com