ArmadaCare®

DIRECT DEPOSIT AUTHORIZATION FORM

Member Reimbursement Method: Direct Deposit

Authorization for Direct Deposit (ACH Credit)

Complete and submit this form to receive your claim reimbursement directly to your bank account.

Participant Information

First Name	Last Name	Employer
SSN #	Email	Daytime Phone

Financial Institution Information

I hereby authorize ArmadaCare, LLC and its affiliate Armada Administrators (collectively "Armada") to initiate credit entries for reimbursements under my ArmadaCare plan to my deposit account indicated below ("My Account"), and to initiate, if necessary, debit entries and appropriate adjustments for any credit entries to My Account at the financial institution named below, hereinafter called BANK, to credit and/or debit the same to My Account. Debits will only occur in the event of an error and with prior notice from Armada indicating the reason for the debit, the amount, and the date of such debit.

☐ Initial Request ☐ Change of Information ☐ Cancel Direct Deposit

Bank Name

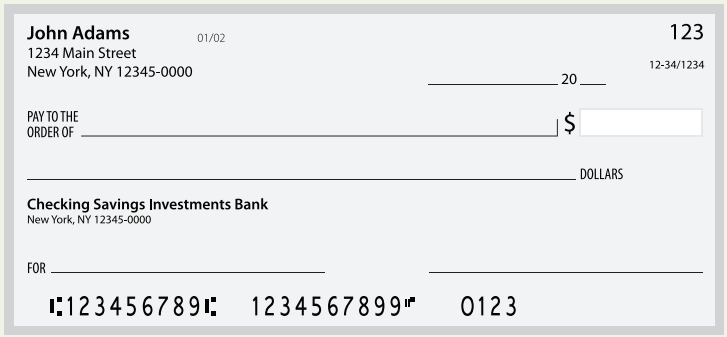
Routing Number

Bank Account Number

Account Name

Type: ☐ Checking ☐ Savings

Attach Voided or Photocopied Check or Savings Account Information



Participant Authorization Signature (required)

This authorization will remain in full force and effect until Armada has received written notification from me of its termination in such time and in such manner as to afford Armada and the Financial Institution a reasonable opportunity to act on it. I acknowledge that it is my responsibility to fill out a new agreement if I change banks or accounts.

Print Name	Employee Signature	Date

Securely Upload or Fax Completed Form To:
Upload: www.armadacare.com/submit
Fax: 1-866-714-6761

Questions?
Email **support@armadacare.com** or call Member Services