



Mail or Fax completed form to:
 MVP Ancillary Services | Attn: Flex Care Program
 620 Erie Blvd. West #200
 Syracuse, NY 13204
 Fax: 1-315-234-6146

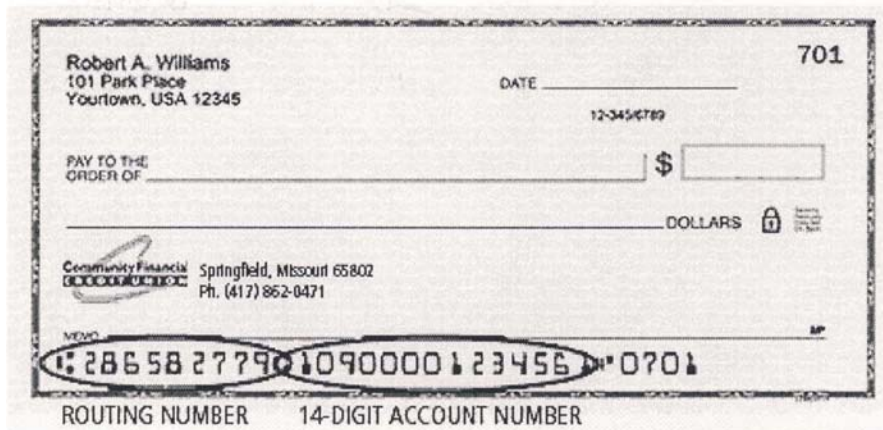


Flexible Spending Account Electronic Funds Transfer Agreement

Last Name	First Name	Social Security Number
E-mail Address	Home Phone Number ()	Daytime Phone Number ()
Payroll Cycle: (select one)	Bi-Weekly (26/Yr)	Semi-Monthly (24/Yr)

Please Select One: NEW ENROLLMENT ACCOUNT CHANGE CHANGE EFFECTIVE DATE: ____/____/____
 CANCEL ELECTRONIC FUNDS TRANSFER CANCEL EFFECTIVE DATE: ____/____/____

Bank Name	<input type="checkbox"/> Checking
	<input type="checkbox"/> Savings
Routing/ABA Number	Account Number



**PLEASE ATTACH A VOIDED CHECK (FOR CHECKING ACCOUNT DEPOSITS) OR
 DEPOSIT SLIP (FOR SAVINGS ACCOUNT DEPOSITS) HERE.**

**THIS MUST BE INCLUDED TO PROCESS –
 INCOMPLETE FORMS WILL BE RETURNED.**

Employee Authorization

I authorize MVP Select Care, Inc. and its financial institution to initiate credit, and if necessary, debit entries, electronically or otherwise, to my checking or savings account. Debit entries will only be made to correct credit entries made in error. Further, I may be responsible for any bank fees incurred due to incorrect account information or account changes that have not been appropriately communicated to MVP Select Care, Inc. This authorization will remain in effect until MVP Select Care, Inc. has received written notification.

Employee Signature: _____ Date: _____

Questions? Please call 1-800-788-8771 or (315) 422-1533