DIRECT DEPOSIT APPLICATION

I: Registered Representative Information - Please Print or Type All Information

Producer: ______________________ SSN/TIN: ______________

Phone: ______________ E-mail: ______________________

Address: ______________________________________

II: Bank Account Information

Action: ☐ Enroll ☐ Change ☐ Cancel

Account Holder Name: ______________________________________

Depository Name: ______________________________________

Bank Address: ______________________________________

Routing Number (ABA): ______________________________________
(9-Digit Bank ID Number)

Account Number (DDA): ______________________________________

Account Type: ☐ Checking ☐ Savings

III: Authorization

Authorized Signature: ______________________________ Date: __________

Print Name: ______________________________

By the signature(s) set forth herein, I/we hereby authorize Flexible Benefits Plans, Inc. to deposit my/our compensation payments directly to the Individual/Corporate Account at the Depository set forth herein. I/we hereby authorize the Depository to accept such deposits and post them to my/our Individual/Corporate Account.

This authorization will remain in full force and effect until Flexible Benefits Plans, Inc. has received writtenh notification of its termination in such time and manner to afford Flexible Benefits Plans, Inc. and my/our Depository a reasonable opportunity to act on it. THIS AUTHORIZATION MAY BE REVOKED ONLY BY NOTIFYING FLEXIBLE BENEFITS PLANS, INC. IN THE MANNER SPECIFIED IN THIS AUTHORIZATION FORM. Furthermore, Flexible Benefits Plans, Inc. has the authority to discontinue the direct deposit service with a 30-day advance notice of such termination.

Flexible Benefits Plans, Inc. shall be entitled to rely upon all Depository information provided on this form (e.g. Depository Name, Depository Account Number, etc.) for as long as this arrangement remains in effect, and Flexible Benefits Plans, Inc. shall incur no liability or loss wahtsoever as a result of relying on any such information. Flexible Benefits Plans, Inc. shall not be required to verify the accuracy of any Depository information (including but not limited to the name on the Depository account) and may rely solely on the Depository account number even if the number identifies a person other than me/us. I/we understand that Flexible Benefits Plans, Inc. liability under the commission schedule/producer agreement is fully satisified by virtue of the direct deposit made, and Flexible Benefits Plans, Inc. is not responsible if someone withdraws such funds.

If for any reason the Depository information changes, it is agreed that it is the sole responsibility of the Account holder(s) to give written notice to inform Flexible Benefits Plans, Inc. as soon as possible of any change, but not less than ten (10) business days prior to the effective date of such change. When changing Depository accounts, it is understood that the current account will be left open until the initial depsoit is made into the new account.

***** This form MUST be accompanied by a Printed Voided Check or Bank Letter*****

Commissions will be generated on the last business day of the month with funds available on the next business day.

IV: Return Form To:

Flexible Benefits Plans, Inc.
PO Box 873
Valley Forge, PA 19482-0873
Phone: 610-482-1800
Fax: 610-482-1803
E-mail: support@flexiben.com