luminare health℠

Benefit Spending Account
Direct Deposit Authorization

EMPLOYEE INFORMATION		
Social Security Number (last 4 digits)	Name (Last, First, M.I.)	Company Name

Would you like to receive your payment information electronically? (If yes, please include e-mail address) ☐ Yes E-mail Address _____ ☐ No	Type of Transaction (Check only one) ☐ Enroll ☐ Change ☐ Cancel

ACCOUNT INFORMATION		
Bank Transit Routing Number (9 digit number)	Bank Account Number	Account Type (Please check one box) ☐ Checking ☐ Savings

EMPLOYEE AUTHORIZATION

I hereby authorize LUMINARE HEALTH to initiate deposits to my account shown above. This authorization will remain in effect until revoked in writing from me or until my participation in the Benefit Spending Account has terminated.

Employee's Signature	Date

Attach a voided check for checking account

Submit authorization electronically at www.myLuminareHealth.com /
click Benefit Spending Accounts link.
Or return this form to: Benefit Spending Accounts
P. O. Box 2968 • Clinton, IA 52733
Phone: 877-267-3359 • Fax: 866-514-8287 • Email address: FlexHB@LuminareHealth.com

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.