



DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize and request A Plus Benefits Inc. to make electronic deposits of any amounts owing to me by initiating credit entries to my account indicated below, in the financial institution named below, hereinafter called bank. I also authorize A Plus Benefits, Inc. to debit my account if an error has occurred and circumstances require that such error be corrected.

It is understood that this agreement may be terminated by me at any time by notification to A Plus Benefits, Inc. Any such notification shall be effective only with respect to entries initiated by A Plus Benefits, Inc. After receipt of such notification and a reasonable opportunity to act on it. A fifteen (15) day initial processing period may be required for setup.

Please Provide the Following Information

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	CLIENT COMPANY
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PLEASE CHECK ONE OF THE FOLLOWING

<input type="checkbox"/> START	<input type="checkbox"/> STOP	<input type="checkbox"/> CHANGE AMOUNT
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PLEASE CHECK ONE OF THE FOLLOWING	PLEASE CHECK ONE OF THE FOLLOWING
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<input type="checkbox"/> DEPOSIT PAYROLL CHECK	<input type="checkbox"/> SAVINGS ACCOUNT
<input type="checkbox"/> DEPOSIT \$ _____ AS DEDUCTED	<input type="checkbox"/> CHECKING ACCOUNT

BANK NAME	BANK PHONE #
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BANK STREET ADDRESS	CITY	STATE	ZIP
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TRANSIT / ABA#	ACCOUNT #
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EMPLOYEE SIGNATURE	DATE
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PLEASE INCLUDE A COPY OF A VOIDED CHECK FOR THE ACCOUNT



For Company Use Only

Company Number	Client Number
Completed By	Effective Date