

AUTHORIZATION FOR PRE-TAX DIRECT DEPOSIT
Enrollment, Change and Cancellation Authorization

Please read all of the information on this form carefully. Please Print.

When completed return to: **Aetna Inc.**
1000 Middle Street, FSA/MC3N
Middletown, CT 06457

Authorization Information. Indicate by checking the appropriate box, whether you are enrolling for Direct Deposit, making a change to or canceling a previous authorization.

ENROLL **CHANGE** **CANCEL**

Personal Information

Complete all of the information below. Especially important is your Social Security number--BE SURE TO INCLUDE IT BELOW.

EMPLOYEE INFORMATION

Name(s) _____ Home Telephone Number (____) _____ - _____
Social Security Number _____ - _____ - _____ Business Telephone Number (____) _____ - _____
Street _____ Employer **EXXONMOBIL/CONTROL NO. 721002**
City _____ State _____ Zip _____

Account Information

Complete this section for direct payments to either your U.S. checking or U.S. savings account.

Keep in mind that in order to take advantage of direct deposit, your bank MUST be a participating member of the AUTOMATED CLEARING HOUSE (ACH) Association. Please check with your bank to make sure they participate before completing this form.

If you want your spending account reimbursements deposited into your checking account, please attach voided check to this enrollment form.

TO BE COMPLETED

BANK NAME: _____	ADDRESS: _____
BANK ID (first 8 digits of the routing number): _ _ _ _ _ _ _ _	
BANK SCD (Self-Checking Digit--the last digit of the routing number): _	
ACCOUNT NUMBER: _____	ACCOUNT TYPE: Savings <input type="checkbox"/> Or Checking <input type="checkbox"/>

Authorization Agreement for Direct Deposit Of Benefit Payments. Read the authorization and sign your name below.

I hereby authorize Aetna Inc. to initiate credit entries to my account at the bank listed above for all unassigned flexible spending account reimbursements on behalf of myself and my dependents, if any. This agreement will remain in effect until I notify Aetna Inc. Member Services of the desire to cancel or change this service. I understand that I must allow reasonable time for my instructions to be executed. I understand that reimbursements will be credited 3 banking days after the regularly scheduled draft run assuming I have a claim processed.

Authorized Signature _____ Date _____