Empower
A Family Health America Company

BANKING INFORMATION FORM
For Debit Card and/or Daily Claims Payment Plans

This form allows EMPOWER to write checks from your designated bank account below to pay participant claims each day. The signature below should be that of the individual who is authorized to sign your company checks.

(Please use black ink only to complete this form)

COMPANY NAME _____
Contact_____
Phone _____ Email _____
Address _____
City, State, ZIP _____
Name of Financial Institution _____
Branch _____ City _____ State _____
Routing # _____Account #_____ Starting Check Numer _____

To insure the proper setup of the debit card linkage (for debit card enabled account), please provide the bank with the following information:

IMPORTANT!
Company Name: MHM Resources LLC
Description: National Flex Trust (Manual Pull)
Description: Direct Pay (Automated Pull)
Company ID: 2206003019

Please attach a copy of a voided check, if available.

IMPORTANT! SIGNATURE OF THE AUTHORIZED SIGNER(S)
Please use the following guidelines to provide EMPOWER with the signature or signatures of the authorized signer(s) on the account:

- The signature should be written on a separate blank sheet of paper using a fine black felt tip marker or sharpie.
- The signature should be the same size it would appear on a check exactly as the bank requires it.
- If multiple signatures are required on the check, please include all signatures.
- **Please return this sheet and the separate signature pages(s) by email to ashley@familyhealthamerica.com.**

(For EMPOWER's use only, Company Code for this signature _____)