Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Direct Deposit Authorization

Send to:
Email: claims@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

Health Risk Services Inc. is pleased to offer you a convenient alternative to receiving cheques for reimbursement of your Extended Health and/or Dental claim expenses. You may use this form to authorize Health Risk Services Inc. to have your claim reimbursements automatically deposited into your bank account. Once your reimbursement has been deposited into your bank account, you will receive an email notice with a link that will direct you to your Explanation of Benefits.

Please note, that should you choose Direct Deposit you will not be receiving your Explanation of Benefits in the mail, but will have access as described above.

For all Direct Deposit requests regarding claim reimbursements, <u>you must submit one of the following:</u>

- **Physical cheque marked "VOID"**
- **Legible electronic copy of a cheque marked "VOID"**
- **Direct Deposit form (electronic versions from your online banking site are accepted)**

AUTHORIZATION FOR DIRECT DEPOSIT

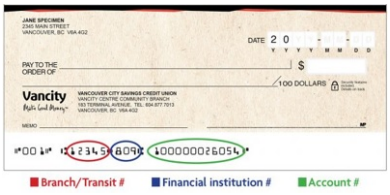
I hereby authorize Health Risk Services Inc. to deposit my Extended Health Care and/or Dental claim reimbursements in the account as outlined on the attached VOID cheque / banking profile.

Employer Name:	**Group Number:**
Employee Name:	**Phone Number:**
Employee Email Address:	
Signature:	**Date Signed: (mm/dd/yyyy)**

PLEASE NOTE THE FOLLOWING:

1. **All information and VOID cheque/banking profile must be included or request cannot be completed.**
2. **This authorization can be cancelled at any time by written request to Health Risk Services Inc.**

Void Cheque Example



I consent to the collection, use and disclosure of my personal information for the purposes of communication, underwriting risks, investigation and adjudication of claims, detection and prevention of fraud, compiling of statistics and acting as required and authorized by law. I also authorize my plan sponsor to this same information for benefits administration and to make any necessary payroll deductions which may be required. **I certify that all information in this form is true and accurate.**

I acknowledge that Health Risk Services Inc. will continue to educate me regarding my benefits program and additional products and services available to myself and my family through Health Risk Services Inc. I am aware that this information may be forwarded through my employer or to my personal residence.