Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Direct Deposit Authorization for Practitioners

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 submitted claims for our mutual clients. You may use this form to authorize Health Risk Services Inc. to have your claim reimbursements automatically deposited into your bank account.

Please note, that should you choose Direct Deposit you will not be receiving an Explanation of Benefits in the mail.

If you wish to have the claims reimbursed by direct deposit, please complete the authorization below; you must also attach one of the following:

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

*** Please note*** should there be multiple practitioners in the same office who would like access to Direct Deposit, each practitioner must fill out and sign an authorization form. We will only require one VOID cheque / banking profile per office if the practitioners share the account.

AUTHORIZATION FOR DIRECT DEPOSIT

I hereby authorize Health Risk Services Inc. to deposit our clients submitted claim reimbursements in the account as outlined on the attached VOID cheque / banking profile.

Business Name and Address:	**Unique ID and Location ID (if applicable):**
Practitioner Name:	**Phone & Fax Number:**
Practitioner 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 the plan sponsor to this same information for benefits administration and to make any necessary 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 our mutual clients benefits programs and additional products and services available to our clients through Health Risk Services Inc.