

# CREDIT AUTHORIZATION FORM

## MEDICAL REIMBURSEMENT/DEPENDENT CARE REIMBURSEMENT

I hereby authorize Sheffield, Olson & McQueen, Inc. to initiate electronic credit entries to my checking/savings accounts at the financial institution listed below, and, if necessary, initiate debit entries and adjustments for any transactions credited in error. This authority will remain in effect until Sheffield, Olson & McQueen, Inc. is notified by me in writing to cancel it in such time as to afford Sheffield, Olson & McQueen, Inc. and the financial institution listed below a reasonable opportunity to act on it.

Please attach a copy of a voided check for checking account transactions or a copy of a savings account deposit slip for saving account transactions. **If you are using a savings account for your transactions, please make sure that you have verified the Financial Institution's Routing Number before submitting this form.**

\_\_\_\_\_  
(Employer)

\_\_\_\_\_  
(Employee Name - PLEASE PRINT)

\_\_\_\_\_  
(Home Phone – include area code)

\_\_\_\_\_  
Enrollee ID #/Social Security #

\_\_\_\_\_  
(Name of Financial Institution)

\_\_\_\_\_  
(Address of Financial Institution - Branch, City, State & Zip)

Account Type:                       Checking                       Savings Account

Account Number: \_\_\_\_\_

Financial Institution Routing Number: \_\_\_\_\_

(Look between these symbols 1: :1 on the bottom left of your check)

\*\*\*\*\**Please staple voided check here*\*\*\*\*\*

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)