MUTUAL
HEALTH SERVICES℠
P.O. Box 5700
Cleveland, Ohio 44101-0700

MUTUAL HEALTH SERVICES
DIRECT DEPOSIT ENROLLMENT FORM

☐ I elect to opt out of electronic claims payment delivery

☐ I elect to opt out of electronic Explanation of Benefits delivery

The following information MUST be completed in full in order to receive Flexible Spending and / or employee paid medical claim reimbursements directly into an account of your choosing.

A VOIDED CHECK OR DEPOSIT SLIP MUST BE ATTACHED IN ORDER TO COMPLETE ENROLLMENT.

SELECT ONE: ☐ INITIAL ENROLLMENT ☐ ACCOUNT UPDATE

NAME_____

SOCIAL SECURITY # _____

BANK NAME _____

BANK ACCOUNT NUMBER_____

BANK ABA/ROUTING NUMBER_____

Note: The routing # on deposit slips is not valid for direct deposit.

ACCOUNT TYPE: ☐ CHECKING ☐ SAVINGS

E-MAIL TO BE USED FOR EOB NOTIFICATION:_____
Please PRINT clearly to ensure proper delivery.

_____
SIGNATURE AND DATE

Please return completed forms and voided check to:

Mutual Health Services
Attn: Member ACH Enrollment
PO Box 5700
Cleveland, OH 44101

Fax: 330-666-6685 / Attn: Member ACH Enrollment