MERS Health Care Savings Program
PO Box 64535 • St. Paul, MN 55164-0535
866.808.7823 (option 3)
www.mersofmich.com

Health Care Savings Program Direct Deposit Agreement

Use this form if you are establishing or updating banking information associated with your MERS Health Care Savings Program account. This information can also be managed securely using your myMERS account. Simply log in and click the "Claims Management" link in your left-hand navigation to avoid submitting this paper form!

Submit your reimbursement electronically!

You have several options:

- Upload your Reimbursement Claim Form using your myMERS account at *www.mersofmich.com.*
- Download the Alerus Health Benefits app and attach your receipt using your mobile device's camera.
- Set up direct payment to the provider by uploading a copy of the bill you received from your doctor's office. Assets from your Health Care Savings Program account will be used to directly pay the bill.

Please print clearly • Retain copy for your records

1. Information about you

Last name*	First name*	Last four digits of SSN*	Phone number (with area code)*

Type of application (select only ONE): ☐ New ☐ Change

2. Account information

☐ Checking account ☐ Savings account

Financial Institution name		
Address		Phone
City	State	Zip
ABA routing number (9 digit)		Account number

3. Required signature

I request that my reimbursements be electronically transferred to my account in the designated financial institution above. This agreement remains in effect until cancelled by me with written notice to MERS or upon my death or legal incapacity. I direct the financial institution to refund to MERS HCSP any money paid by it to which I was not entitled and to allow MERS HCSP unrestricted access to my account for reclaiming such overpayments. I agree to comply with the State of Michigan rules concerning electronic funds transfers. Michigan law governs electronic funds transactions in all respects except as otherwise superseded by federal law. I understand that I will be notified of any rule changes that affect my direct deposits. I have notified my joint account holder(s) of the obligations to repay any overpayment to this account after my death if the overpayment is not repaid by the financial institution.

Payee signature*	Date (mm/dd/yyyy)*

* Required field

Please mail completed form to:

Alerus Retirement and Benefits
ATTN: Health Benefits Department
PO Box 64535
St. Paul, MN 55164-0535

Questions about completing this form?
Please contact us at 800.767.MERS (6377)

Questions on claims status or reimbursements?
Please contact Alerus at 866.808.7823 (option 3)