



**FLEXIBLE BENEFITS PLAN  
DIRECT DEPOSIT CANCELLATION FORM**

Instructions: Complete the Direct Deposit Cancellation Form. Your signature is required to process this request. After completing this form:

*Mail to:*

HealthComp  
Flexible Benefits Department  
P.O. Box 45018  
Fresno, CA 93718-5018

Or,

*Email to:*

flexbenefits@healthcomp.com

**I hereby request HealthComp cancel my Direct Deposit Authorization Agreement**

**Name of Employer:**

**Daytime Phone:**

**Name of Employee (Last, First, M.I.):**

**Social Security #:**

**Address, City & State, Zip:**

**E-mail Address:**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**