

**L.R. Webber Associates
Reimbursement Authorization Form
DCA Reimbursement Plan**

Employer Name: _____

Name _____ Social Security Number _____

I elect to receive disbursements from my DCA reimbursement plan in the following manner:

- Deposited directly into my account (choose one account type)

Bank Name: _____

Bank Routing # _____

Checking Account # _____

Savings Account # _____

Please attach a copy of a voided check

Signature

Date