



**AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

Employer Name	
Employee Last Name, First	Date of Birth
Street Address, City & State	Zip Code
Phone Number	

I (we) hereby authorize Employer Plan Services, Inc. (Administrator for Mohawk/Dal-Tile/Unilin Health Care Flexible Spending Account), hereinafter called Company, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my our (\_\_\_) Checking (\_\_\_) Savings account (select one) indicated below and the depository named below, hereinafter called Depository, to credit and/or debit same to such account.

Depository Name \_\_\_\_\_ Branch \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Transit/ABA No. \_\_\_\_\_ Account No. \_\_\_\_\_

This authority is to remain in full force and effect until Company and Depository has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

Name(s) \_\_\_\_\_ ID/SSN No. \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_

EMPLOYER PLAN SERVICES, INC.  
2180 NORTH LOOP WEST #400  
HOUSTON, TEXAS 77018  
PHONE: (866)369-0705  
FAX: (713)369-0703