Employee Compensation and Benefits Disbursements

Direct Deposit Authorization Agreement

❍ New ❍ Change ❍ Cancel*

Name (Please print): _____

Terminal/Dept.: _____ SSN: | | | | — | | | — | | | | |

I authorize Arkansas Best Corporation and the financial institution listed below to deposit my pay electronically to my account each payday. Additionally, I authorize Choice Benefits, Arkansas Best Corporation, and the financial institution listed below to deposit my Flexible (Health Care and Dependent Day Care) Spending Account Payments and Choice Benefits Health Claim Reimbursement Payments to my account, when applicable. If funds to which I am NOT entitled are deposited to my account, I authorize Arkansas Best Corporation to direct the financial institution to return said funds. This authority will remain in effect until Arkansas Best Corporation has received notification from me to cancel the authorization, until I have signed a new authorization agreement, or upon termination of my employment.

☐ **I elect NOT to participate in Choice Benefits Direct Deposit at this time. I wish to receive my Benefits Disbursements by check.**

*Please be advised that your Cancellation of *Employee Compensation (Payroll) Direct Deposit*, automatically cancels your *Choice Benefits Direct Deposit*.

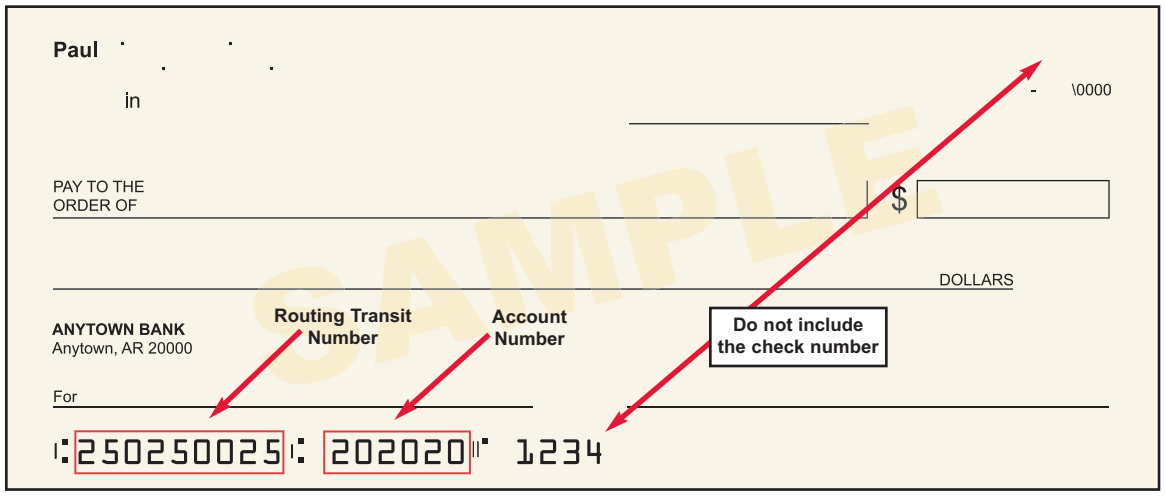
Please check one: ❍ Checking Account ❍ Savings Account

Routing Transit Number (RTN): _____ Account No.:_____

Financial Institution Name: _____ Phone No.:_____

City: _____ State:_____

Signature: _____ Date:_____



Important:

We recommend that you attach a copy of a voided check for accuracy.
Please complete this form (either electronically or manually) and mail to the address below:

Arkansas Best Corporation

P.O. Box 10048
Fort Smith, AR 72917-0048

USE THIS FORM FOR EMPLOYEE COMPENSATION AND BENEFITS DISBURSEMENTS