



Authorization for Direct Deposit of Wellness Incentive Payment

Please fill out and return to the Group Insurance Division

I authorize the State of Illinois to initiate electronic credit entries and the financial institution listed below to receive credit entries, and if necessary, reversing credit entries for any credit given in error or not owed to my account, each payment period. This authority will remain in effect until I have canceled it in writing.

1. Name (First, Middle initial, and Last)		2. Social Security Number (Last 4 digits)
3. Employee ID Number		4. Check One Checking ☐ Savings ☐
5. Financial Institution: Name and City		
6. Account Number		7. Bank Transit Routing Number (9 digits)
8. Daytime Phone Number	9. Date	10. Signature

For any questions, please contact the Analysis and Resolution Unit at
1-800-442-1300 or CMS.Ben.ARU@illinois.gov

CMS Bureau of Benefits
Group Insurance Division
Analysis and Resolution Unit
PO Box 19208 Springfield, IL
62794-9208

[Click to submit by email](#)

If returning by mail please send to the Analysis and Resolution Unit address listed above.