

AGT# \_\_\_\_\_

## Direct Deposit Authorization Form

This authorizes Insurance Benefit Administrators to send credit entries (and appropriate debit and adjustment entries) electronically, or by any other commercially accepted method, to my (our) account indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

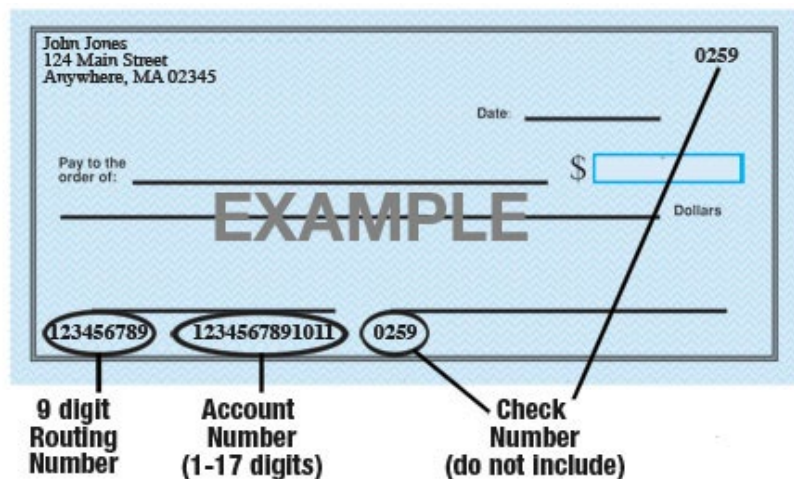
Please print and complete **ALL** information below.

Individual Name or Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_



Name of Bank: \_\_\_\_\_

9-Digit Routing #: \_\_\_\_\_

Account #: \_\_\_\_\_

Type of Account:     Checking     Savings    (Check One)

**You may attach a voided check for the bank account to which funds should be deposited.**

Insurance Benefit Administrators is hereby authorized to directly deposit my check to the account listed above. This authorization will remain in effect until Insurance Benefit Administrators has received a written termination notice.

Authorized Signature: \_\_\_\_\_

Print Name/Title (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_