



Commission Direct Deposit

Complete this form to receive commissions via Direct Deposit. Allow up to 30 days for your request to be processed.

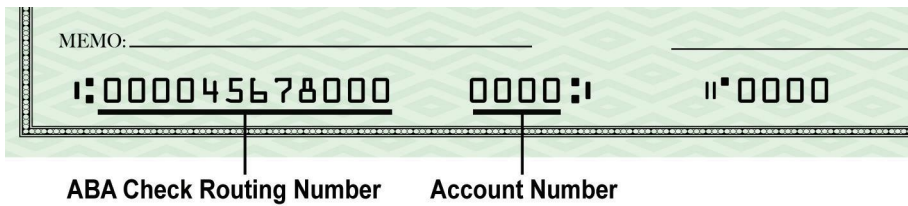
Agency/Broker Name (as it appears on account): _____

Bank Name: _____

ABA Number/ Check Routing Number: _____

Bank Account Number (must be a checking account): _____

Please attach a voided check - form will not be processed without this information. Scanned or faxed copies are acceptable.



I hereby authorize HealthPass to initiate a Direct Deposit to my account for payment of my monthly commissions. The account will be credited on or about the 15th of each month. I understand that if I make changes to my banking arrangements I must notify HealthPass in order for the successful completion of the deposit.

Broker Signature: _____

Date: _____ HealthPass Broker ID#: _____

Submit by:
Fax - 212-252-7448
Email - sales@healthpassny.com