Commission Direct Deposit

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

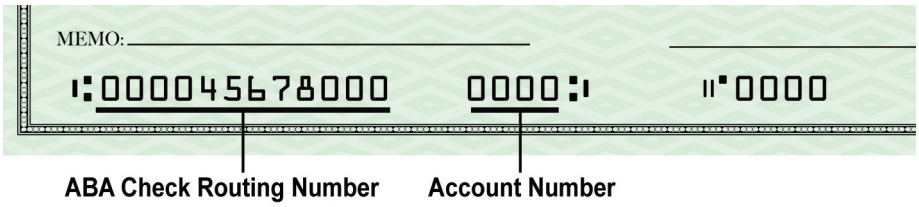
Agency/Broker Name (as it appears on account):_____

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 mail:
HealthPass New York
Attn: Sales Support
80 Pine St, 29th FL
New York, NY 10005

Submit by email:
sales@healthpassny.com