Commission Direct Deposit

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

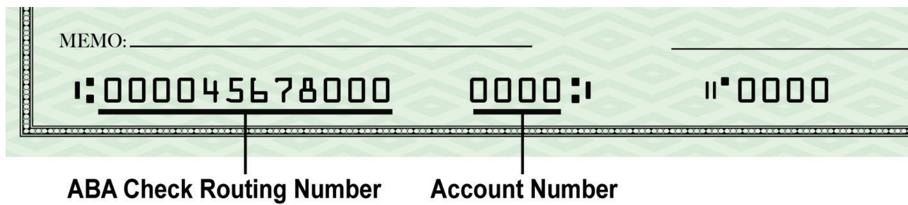
Agency/Broker Name (as it appears on account):______________________________________

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