



Direct Deposit Authorization For Broker Commission Payment

Agency/Broker Name: _____

Authorization Type: New
 Change
 Cancel

For deposit to: _____
(Name of Financial Institution)

Type of account (check one)

Checking (need voided check)

Savings

Account #: _____

ABA Transit #: _____

I hereby authorize MVP Health Plan, Inc. and its affiliates to honor the direct deposit instructions indicated above. This request is to remain in effect until changed by me in writing by submitting a new Direct Deposit Authorization. I also agree that, in consideration for this service, any funds erroneously deposited in my account in excess of my authorized amount may be withdrawn by **MVP Health Plan, Inc. and its affiliates** without liability or prior notice.

Authorized Signature: _____ Date: _____
(must be signed by an officer of the company)

PLEASE TAPE/STAPLE YOUR VOIDED CHECK HERE

Please return form and voided check, if applicable, to:
MVP Health Care - Accounts Payable
625 State Street
Schenectady, NY 12305

For any questions, please contact Josie Malinoski at (518) 388-2098.