ibs adminSM

ADM USE ONLY

AGT#____________________

Direct Deposit Authorization Form

This authorizes Insurance Benefit System 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.

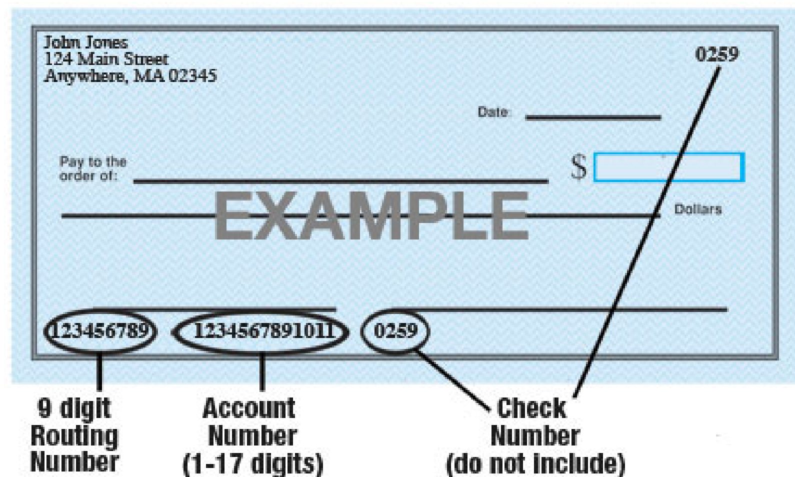
Please print and complete **ALL** information below.

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

Authorized Signature: ______________________________

Print Name/Title (if applicable): ______________________________

Date: ____________________