



**Authorization for Direct Deposit**

Company Name: \_\_\_\_\_

Contact Name & Phone: \_\_\_\_\_

Federal ID Number: \_\_\_\_\_

**Account Information**

Bank or Credit Union Institution: \_\_\_\_\_

Bank Telephone No.: \_\_\_\_\_

Branch: \_\_\_\_\_

Acct. Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Acct. No.: \_\_\_\_\_ **ABA/Transit Routing No.:** \_\_\_\_\_

**(9-digit number)**

I authorize ConnectiCare to remit payment via electronic transfer to the bank account listed below.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*Please include either a voided/canceled check OR Bank Spec Sheet to validate this Direct Deposit.\*\***

*Note: You must notify ConnectiCare's Finance Department at least 10 business days prior to changing or cancelling your bank information.*

Fax/Mail to: Finance Department  
Attn: Broker Commissions  
ConnectiCare, Inc.  
175 Scott Swamp Road  
Farmington, CT 06032  
fax (860) 678-5224

**Internal Use Only**

Form Received: \_\_\_\_\_ EFT Effective Date: \_\_\_\_\_

*ConnectiCare Proprietary Information*