ConnectiCare, Inc.

**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: _____