AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS

A copy of a voided check must be included with this form to process direct deposits
Recipient Name and Tax ID must match W9 Name and Social or EIN

RECIPIENT NAME: ____

RECIPIENT TAX ID#: ____

I, ____ hereby authorize Mutual Med hereinafter called COMPANY, to initialize credit entries to my (our) :

Checking Account
Savings Account

Indicated at the depository institution named below, hereinafter called DEPOSITORY, and to credit the same to such account.

DEPOSITORY NAME: _______________________________________ BRANCH: ___________________

CITY: _________________________________ STATE: ____________ ZIP: ______________________

ROUTING NUMBER: ____________________________ ACCOUNT NUMBER: _____________________

This authorization is to remain in full force and effect until COMPANY has received written notification from me (us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. No money will be withdrawn from your account as a result of this authorization.

NAME(S) ____

(please print)

SIGNED: ____DATE: _______________________

Please note: All written credit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

EMAIL ADDRESS FOR COMMISSION STATEMENTS: ____

PLEASE DEPOSIT COMMISSIONS (Please select one) :

Last business day of current month
First business day of following month