Direct Deposit Authorization Form

BROKER COMMISSION

Section 1: TYPE OF REQUEST

❑ New ❑ Change ❑ Cancel

Section 2: BROKER INFORMATION

Broker/Agency Name _____

WHA Broker/Agency Identification No. _____

Tax ID (TIN)/Social Security No. _____

Broker/Agency Phone Number _____

Broker/Agency Mailing Address _____

City/State/Zip _____

Broker/Agency Email Address _____

Section 3: BANKING INFORMATION

Bank Name (Receiving Bank) _____

Bank City/State/Zip _____

Name on Bank Account _____

Routing Number _____

Account Number _____

Section 4: AUTHORIZATION

I certify that the information provided on this form is correct, and that I am authorized to sign this form for the above-named company. I hereby authorize Western Health Advantage ("WHA") to electronically deposit payments to the bank account designated above. This authorization will remain in effect until I give written notice of change or cancellation, or until WHA notifies me that this service has been cancelled. I understand that a new authorization must be completed if there is a change to my bank account, my bank account is closed, or there is a change in financial institutions, and that such changes may take up to 30 days to be effective.

Authorized Signature _____ Date _____

Print Name _____ Title _____

Return completed form with a VOIDED CHECK to Western Health Advantage by mail, fax, or email.

Western Health Advantage
Attn: Commission Support
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Fax: 916.568.1338
Email: commission.support@westernhealth.com