



## Direct Deposit Agreement Form

### Authorization Agreement

I hereby authorize **Easy Choice Health Plan of NY** to initiate automatic deposits of all of my commissions to my account at the financial institution named below. I authorize **Easy Choice Health Plan of NY and ADP** to withdraw any funds deposited in error into my account.

Further, I agree not to hold **Easy Choice Health Plan of NY** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Easy Choice Health Plan of NY** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to Atlantis Health Plan.

Broker Name: \_\_\_\_\_ Broker/GA Number: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

### Account Information

Checking  Savings

Name of Financial Institution: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Cancellation of Authorization

### Signature

Authorized Signature  
(Primary): \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Signature (Joint): \_\_\_\_\_ Date: \_\_\_\_\_

**Please attach a voided check or deposit slip and return this form to:**  
**Easy Choice Health Plan of NY**  
**Attention: Sales Support & Installation**  
**45 Broadway, Suite 300**  
**New York, NY 10006**



AHP-00113  
Revised 04/08