Direct Deposit Agreement Form

Authorization Agreement

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

Further, I agree not to hold **Atlantis Health Plan** 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 **Atlantis Health Plan** 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:
Atlantis Health Plan
Attention: Sales Support & Installation
45 Broadway, Suite 300
New York, NY 10006

ATLANTIS HEALTH PLAN
By Doctors. For New Yorkers.