Underwritten by MotivHealth

EFT Request Form

BROKER/ AGENCY INFORMATION

Entity to be paid: ☐ Broker ☐ Agency ☐ General Agent

Name of Entity _____ Entity TIN/SSN#_____

Please choose one of the following options:

☐ Elect EFT Payments ☐ Change EFT Information ☐ Receive a Check

BANKING INFORMATION

(Only complete if EFT Payment or Change option has been chosen)

I (we) authorize Start Health to initiate credit entries to my (our):

☐ Checking Account ☐ Savings Account

Name of Financial Institution .....

Name of Account .....

Account# ..... Routing# _____

IMPORTANT NOTICE: It is the applicant's responsibility to ensure that the information provided on this form is complete and accurate. MotivHealth Insurance Company will not be responsible and shall be held harmless for errors made in the EFT payments that are a result of inaccurate or incomplete information provided on this form. In no event and under no circumstances will the liability of MotivHealth Insurance Company exceed the amount of the EFT payments in question.

Authorized Signer _____ Date _____

Print Name _____ Title _____

ATTACH A VOIDED CHECK HERE

(Do not use a checking deposit slip for EFT deposits. Deposit slips do not always contain the necessary routing and transit information.)