Avera Health Plans

Automatic Commission Direct Deposit Authorization Agreement (ACH Credits)

To receive your monthly commissions directly deposited into your checking account, please:

1. Complete, sign and date the authorization agreement form;
2. Provide a copy of a voided check to ensure we have the correct banking information;
3. Mail the original form to Avera Health Plans and
4. Retain a copy of this form for your files.

IMPORTANT: We will not be able to process an incomplete form. Please print clearly.

This agreement request is: ☐ New ☐ Change ☐ Cancellation

Agent/Agency Name: _____ Social Security Number/TIN: _____

Business Address: _____ ZIP: _____

Business Phone: _____ Email: _____

BANKING INFORMATION

_____

Financial Institution Name Phone Number

_____

Financial Institution Street Address City State ZIP

_____

Name on Bank Account

☐ Checking Account Number (attach copy of a voided check): _____

(or)

☐ Savings Account Number (contact financial institution for proper account number): _____

Routing/ABA Number: _____

NOTE: Checking account routing numbers are the nine digits printed on the bottom of check between ⑆ ⑆ these characters. If you elected to use your saving account, please contact your financial institution to obtain proper routing number.

I (agent) hereby authorize Avera Health Plans and the financial institution named above to initiate automatic Automated Clearing House (ACH) credit entries and, if necessary, debit entries and/or adjustments for any entries made in error to the above designated bank account. This authorization will remain in effect until Avera Health Plans has received written notification of its termination in such time and in such manner as to afford Avera Health Plans and my financial institution a reasonable opportunity to act on it. I agree to notify Avera Health Plans of any changes to the banking information that I have provided. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the U.S. law.

AUTHORIZATION AGREEMENT MUST BE SIGNED BY THE AUTHORIZED BANK ACCOUNT HOLDER:

_____ _____

Signature of Bank Account Holder Date Signed

Please mail the completed authorization agreement to: Avera Health Plans, Attn. Finance Dept.
5300 S Broadband Ln
Sioux Falls, SD 57108-2221

Email to: financeahp@avera.org

Direct deposits are processed on the 15th day of the month. If the 15th day is on a weekend or holiday, the automatic deposit will be processed on the next business day. If you have any questions concerning your AUTOMATIC COMMISSION DIRECT DEPOSIT FOR AUTHORIZATION AGREEMENT, please contact our Customer Care Team at 605-322-4545 or toll-free at 1-888- 322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday.