



Distributor Direct Deposit Authorization

**Instructions**

Please complete Parts A through C, attach a voided check, and return to the Home Office with your contracting papers.

**Part A: Bank Account Holder Personal Information – Please Print**

Name \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Phone No. \_\_\_\_\_ E-mail Address \_\_\_\_\_

**Part B: Bank Account Information**

Start Direct Deposit  Change Account Information

Please Attach A Voided Check

Checking  Savings

Routing Number 

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Account Number 

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**Part C: Bank Account Holder(s) Signature(s)**

I (We) give permission to Medico™ Insurance Company to automatically make payments to my (our) bank account of my commissions. This authorization will remain in force unless I (we) cancel it or my (our) bank account is closed.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
As it appears on bank records.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
If joint account.

Printed Name \_\_\_\_\_