

## PROVIDENCE HEALTH PLANS DIRECT DEPOSIT AUTHORIZATION FORM

**INSTRUCTIONS:** Please use only blue or black pen. Initial any corrections.

### SECTION 1: TYPE OF ACTION

- New direct deposit authorization (complete sections 2,3 & 4)
- Change financial institution and/or bank account (complete sections 2,3 & 4)
- Cancellation of direct deposit (complete sections 2& 5)

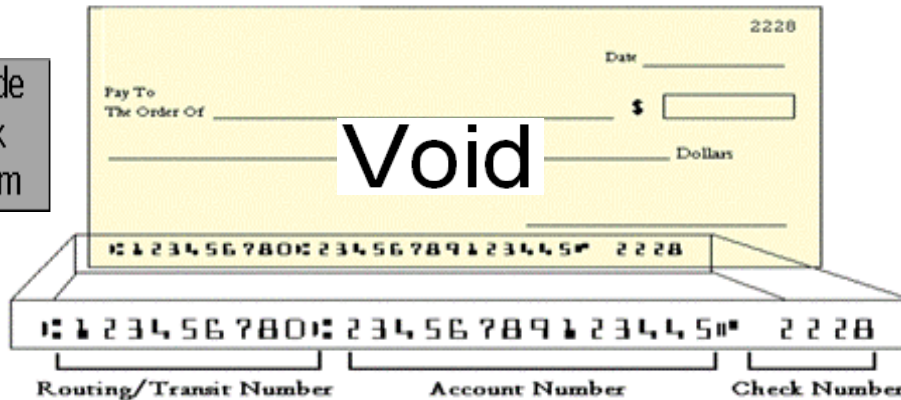
### SECTION 2: PAYEE INFORMATION

Name: \_\_\_\_\_  
 Mailing address: \_\_\_\_\_  
 City: \_\_\_\_\_ State & Zip Code: \_\_\_\_\_  
 Phone number: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

### SECTION 3: FINANCIAL INSTITUTION INFORMATION

Financial institution name: \_\_\_\_\_  
 City and state: \_\_\_\_\_  
 Type of account:  Checking  Savings  
 Routing/Transit number (see example below): \_\_\_\_\_  
 Account number (see example below): \_\_\_\_\_

Please include  
voided check  
with this form



### SECTION 4: AUTHORIZATION FOR NEW OR CHANGED ACCOUNTS

I authorize Providence Health Plans (PHP) and my financial institution indicated above to make deposits to my account. If funds to which I am not entitled are deposited to my account, I authorize PHP to direct the financial institution to return such funds and notify me. This authorization will remain in effect until PHP receives a new authorization from me either changing or canceling this authorization.

Authorized signature: \_\_\_\_\_  
 Printed name: \_\_\_\_\_  
 Date: \_\_\_\_\_

### SECTION 5: AUTHORIZATION FOR CANCELLATION

I request that Providence Health Plans (PHP) and my financial institution indicated above terminate direct deposits to my account. I understand that it may take 30 days for the cancellation to take effect.

Authorized signature: \_\_\_\_\_  
 Printed name: \_\_\_\_\_  
 Date: \_\_\_\_\_

**Fax to: Attn Agent Coordinator (503) 574-8150**