

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

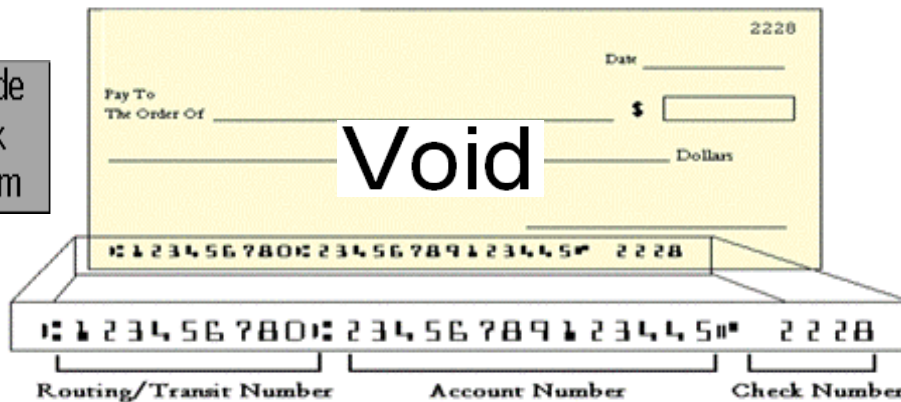
SECTION 2: PAYEE INFORMATION

Name: _____
 Mailing address: _____
 City: _____ State and 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