Fallon Community Health Plan
Broker Direct Deposit Application

Registered Representative Information – Please print or type all information
Application must be completed throughout by an authorized officer of the agency.

I would like to:
❑ Elect direct deposit ❑ Change direct deposit information ❑ Cancel direct deposit

Payee name/firm:_____ Agency ID#:_____

Phone:_____ E-mail :_____

Business address: _____

City: _____ State: _____ ZIP: _____

I (we) _____, authorize Fallon Community Health Plan (FCHP) to electronically credit my/our account
Broker/Broker agency name
(and, if necessary, to electronically debit my (our) account to correct erroneous credits). I (we) agree that FCHP transactions I (we) authorize comply with all applicable laws.

Bank account information
Account holder name:_____

Bank name _____ City, State ZIP:_____

Routing number (ABA):_____
9-Digit bank ID number

Account number (DDA)_____

I (we) understand that this authorization will remain in full force and effect until I (we) notify FCHP in writing that I (we) wish to revoke this authorization. I (we) understand that FCHP requires at least two weeks prior notice in order to cancel this authorization.

Name(s): _____
(Please print)

Date: _____ Signature(s): _____

By the signature(s) set forth herein, I/we hereby authorize Fallon Community Health Plan, Inc. ("FCHP") to deposit my/our compensation payments directly to the individual/corporate account at the Depository set forth herein. I/we hereby authorize the Depository to accept such deposits and post them to my/our individual/corporate account. This authorization will remain in full force and effect until FCHP has received written notification of its termination in such time and manner as to afford FCHP and my/our Depository a reasonable opportunity to act on it. THIS AUTHORIZATION MAY BE REVOKED ONLY BY NOTIFYING FCHP IN THE MANNER SPECIFIED IN THIS AUTHORIZATION FORM. Furthermore, FCHP has the authority to discontinue the direct deposit service with a 30-day advance notice of such termination.

FCHP shall be entitled to rely upon all Depository information provided on this form (e.g., Depository name, Depository account number, etc.) for as long as this arrangement remains in effect, and FCHP shall incur no liability or loss whatsoever as a result of relying on any such information. FCHP shall not be required to verify the accuracy of any Depository information (including but not limited to the name on the Depository account) and may rely solely on the Depository account number even if the number identifies a person other than me/us. I/we understand that FCHP's liability under the commission schedule/producer agreement is fully satisfied by virtue of the direct deposit made, and FCHP is not responsible if someone withdraws such funds. If necessary, FCHP or its affiliates may process withdrawal adjustments to this account in the event of overpayment.

If for any reason the Depository information changes, it is agreed that it is the sole responsibility of the account holder(s) to give written notice to inform FCHP as soon as possible of any change, but not less than ten (10) business days prior to the effective date of such change. When changing Depository accounts, it is understood that the current account will be left open until the initial deposit is made into the new account.

Submit completed broker direct deposit application to:

E-mail: AccountsPayable@fchp.org

Mail: Manager of Accounts Payable
2nd floor
Fallon Community Health Plan
One Chestnut Place
10 Chestnut St.
Worcester, MA 01608

fallon community health plan