WELLFLEET
WORKPLACE

DIRECT DEPOSIT REQUEST AUTHORIZATION

Name on Account:

_____ ___ _____
First Name MI Last Name

Address on Account:

_____ _____ ____ _____
Street Address City State Zip

Phone: _____ Email: _____

Banking Information:

_____
Bank Name

_____ _____ **Account type**: ☐ Checking
Routing Number (9 digits) Account Number ☐ Savings

ATTACH VOIDED CHECK HERE

I (we) authorize Wellfleet Insurance to initiate credit entries to my (our) account indicated above.

_____ _____
Authorized Signature Date

Please return form with filed claim to: Wellfleet Insurance
P.O. Box 15769
Springfield, MA 01115
1-855-664-5838 1-413-452-5486 (Fax)
Email: workplaceclaims@wellfleetinsurance.com