WELLFLEET
WORKPLACE

AUTOMATIC WITHDRAWAL REQUEST AUTHORIZATION

Name on Account:

_____ ___ _____

First Name MI Last Name

SSN: _____

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 automatic withdrwals from my (our) account indicated above.

_____ _____

Authorized Signature Date

Please return form with filed claim to: Wellfleet Insurance
P.O. Box 15769
Springfield, MA 01115
1-855-644-5838 1-413-452-5486(Fax)
Email: workplaceclaims@wellfleetinsurance.com