

DIRECT DEPOSIT REQUEST AUTHORIZATION

Name on Account:				
First Name	MI Last Name			
Address on Account:				
Street Address	City	у	State	Zip
Phone:	Email:			
Banking Information:				
Bank Name				
Routing Number (9 digits)	Account Number	Acc	ount ty	pe: ☐ Checking ☐ Savings
ATTA	CH VOIDED CH	IECK HERE		
I (we) authorize Wellfleet Insurance. t	o initiate credit entri	es to my (our) accoun	t indicat	red above.
Authorized Signature		Date	_	
Please return form with filed claim to:	P.O. Box 15769 Springfield, MA 011	.15 1-413-452-5486 (Fax)		

Email: workplaceclaims@wellfleetinsurance.com