

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS

PLEASE BE SURE TO INCLUDE A COPY OF A VOID/CANCELLED CHECK

RECIPIENT NAME: _____

RECIPIENT TAX ID#: _____

I _____ hereby authorize Mutual Med hereinafter called COMPANY, to initialize credit entries to my (our):

- Checking Account
- Savings Account

indicated at the depository institution named below, hereinafter called DEPOSITORY, and to credit the same to such account.

DEPOSITORY NAME: _____ BRANCH: _____

CITY: _____ ST: _____ ZIP: _____

ROUTING NUMBER: _____ ACCOUNT NO: _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. No money will be withdrawn from your account as a result of this authorization.

NAME(S): _____

(Please print)

SIGNED: _____ DATE: _____

NOTE: ALL WRITTEN CREDIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

EMAIL ADDRESS FOR COMMISSION STATEMENTS: _____

- PLEASE DEPOSIT COMMISSIONS:
- Last Business Day of Current Month
 - First Business Day of Following Month