direct deposit authorization form

Electronic fund transfers (EFT) for payments to producers

For checking accounts only

Please see the back of this sheet for instructions on how to complete this form.

Please check one: ☐ New ☐ Cancel ☐ Change

Part 1: Producer data

Please print in blue or black ink.

Producer number
(TIN/SSN)

Producer name | Last | First | Middle

Producer mailing address

City | State | ZIP code

E-mail address (optional)

Part 2: Bank account information

A voided check must accompany this request.

Attach a voided, blank check here.

Bank name | Bank phone number

Bank address

City | State | ZIP code

Name on bank account

Bank account number

Transit/ABA number

(over)

Part 3: Statement and signature

The Producer hereby authorizes payments via EFT. If the Producer has designated a representative, this individual will be the account's contact person and is authorized to make future requests or changes under this authorization on behalf of the producer.

I hereby authorize CareTrust Networks or its affiliates to initiate deposit of my monthly commissions, bonus payments, marketing program reimbursements, any other such payments, and/or corrections to any previous credits, to the financial institution listed in Part 2: Bank Account Information. If necessary, CareTrust Networks or its affiliates may process withdrawal adjustments to this account in the event of overpayment. I understand that the initial set-up and any subsequent change requests may require up to 30 days processing time prior to the effective date, and during that time no payments from CareTrust Networks or its affiliates will be direct deposited. Requests to terminate EFT will take effect in the next process cycle after a request is received. This authorization is to remain in full force and effect until I revoke it by giving 30 days prior notice to:

CareTrust Networks
Attn: Producer Accounting
PO Box 970
Lodi, Ca 95241

Producer name (please print)

Title (if applicable) Phone number

Name of designated representative (if applicable – please print)

Producer signature Date

Instructions for completing your Direct Deposit Authorization Form

Part 1: Producer data

Please provide the information requested.

Part 2: Bank account information

This Direct Deposit Authorization Form instructs us to process your payments via electronic funds transfer (EFT). You may change the way you receive your payments at any time and as often as you want during the time that you receive payments by notifying us in writing. Please allow 30 days for us to process your request. (This means that you should expect to continue receiving your payments as previously indicated until the change has been implemented.)

Please provide the information requested and attach a voided check.

Part 3: Statement and signature

After you have completed Parts 1 and 2, please review your form and read the statement in Part 3. If everything is correct and you understand the information in Part 3, please sign and date Part 3.

Send the form with the voided check to:

CareTrust Networks
Attn: Producer Accounting
PO Box 970
Lodi, Ca 95241