

# Insurance Direct Deposit Authorization

Please change my existing Insurance Direct Deposit.

\_\_\_\_\_  
PROVIDER NAME

\_\_\_\_\_  
PAYEE ID

\_\_\_\_\_  
ADMINISTRATIVE CONTACT

\_\_\_\_\_  
TAX ID

\_\_\_\_\_  
PHONE NUMBER

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Financial Institution Information:

**Ent**  
**P.O. Box 15819**  
**Colorado Springs, CO 80935-5819**  
**719-574-1100**

307070005  
ROUTING NUMBER

\_\_\_\_\_  
ACCOUNT NUMBER AND SHARE ID

\_\_\_\_\_  
NAME ON ACCOUNT

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
DAYTIME PHONE NUMBER

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\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE