MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Authorization Form for Electronic Funds Transfer (EFT) for **Broker Commission Payments**

We now offer the convenience of electronic funds transfer (EFT) for our broker business partners. With this program, you authorize the Health Connector to deposit your commission payments for Business Express directly into your bank account. It's easy to set up. Just complete this form and mail it back to the Health Connector:

Massachusetts Health Connector
Attn: Bill Karger
100 City Hall Plaza
Boston, MA 02108.

Please note that the Health Connector will not be issuing paper checks. Commissions will only be available through EFT.

Once we receive your EFT form, Commissions will be generated on the 20th of the month for premium payments received in the previous month. For example, commissions generated in October 2015 will be for premium payments received in September 2015 (the month the group is billed for October coverage). Commission rates are paid per the current year commission schedule.

STEP 1 Tell us about your brokerage firm or agency.

Name of brokerage firm or agency		
Name of broker		
Business address		Unit or suite number
City	State	ZIP code
Company phone	Company fax	
Email of person completing this form		

Questions? Contact Bill Karger at **617-933-3042** or **William.Karger@state.ma.us**

09-2014-ENG

STEP 2 Tell us about your bank account.

Please choose one of these options: ☐ Start EFT ☐ Stop EFT ☐ Change EFT

Please attach a voided check. When providing the account and routing or transit numbers, please refer to the series of numbers located at the bottom of your check and insert those numbers below.

Type of account *(check one)*: ☐ Checking or ☐ Savings account

Name on the account *(Please list all names that appear on this account)*

Name of financial institution

City	State	ZIP code

Account number	Routing or transit number
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STEP 3 Read and sign this form.

Important note: It is the applicant's responsibility to ensure that the information provided on this form is complete and accurate. The Health Connector is not responsible and shall be held harmless for errors made in EFT payments that are a result of inaccurate or incomplete information provided on this form. The Health Connector shall not be required to verify the accuracy of any depository information (including but not limited to the name on the depository account) and may rely solely on the depository account number even if the number identifies a person other than the applicant. The applicant understands that the Health Connector's liability under the commission schedule is fully satisfied by virtue of the EFT payment made, and the Health Connector is not responsible if someone withdraws such funds. If necessary, the Health Connector or its affiliates may process withdrawal adjustments to his account in the event of overpayment. In no event and under no circumstances will the Health Connector's liability exceed the amount of the EFT payments in question.

This form must be signed by an authorized representative of the firm or agency.

Signature of bank account owner ▶		Signature of brokerage firm authorized representative ▶	
Print name		Print name	
Title	Date	Title	Date

STEP 4 Mail completed form.

To protect the privacy of your financial information, **please do not fax or email** completed form.

Mail your signed form to:
Massachusetts Health Connector
Attn: Bill Karger
100 City Hall Plaza, Boston, MA 02108

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