



AUTHORIZATION FOR DIRECT DEPOSIT/PAYMENT OF AGENCY COMMISSION

I authorize FUBA Workers' Comp and the financial institution named below to initiate entries to my checking/savings account. This authority will remain in effect until I notify FUBA Workers' Comp in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I can stop payment of any entry by notifying my financial institution 3 days before my account is charged.

PLEASE PRINT LEGIBLY AND FAX TO 850-681-0765.

(Agency Name)

(Address)

(City)

(State)

(Zip)

(Print Name of Agency Owner)

(Signature of Agency Owner)

Date

(Financial Institution)

(Branch)

(Address)

(City)

(State)

(Zip)

Email address of person to receive
emailed commission statements: _____

Account No. _____

(Please circle one – Checking account OR Savings account)

Financial Institution Routing Number _____

(If you do not know this number, please call your financial institution.)

PO Box 1303
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www.fubaworkerscomp.com