Authorization for Electronic Funds Transfer (ACH)

Please Print or Type
Please allow 2-3 weeks for direct deposit to take effect

Payee Name	Address	Telephone #
Email Address		Tax ID #

Action (Check one): ☐Enroll ☐Change ☐Cancel

1. I hereby authorize UnitedHealthcare Corporation , 9900 Bren Road East, Minneapolis MN, hereinafter called COMPANY, to initiate credit entries to my account indicated below and the depository name below, hereinafter called DEPOSITORY, to credit the same account.

2. Deposit to the following account:
☐Checking Account ☐Depository Account (ACH ABA number required)

3. To ensure my account is properly credited, I have attached a **voided check** (deposit ticket is not acceptable) containing the Depository Transit/ABA routing number and my account number.

Depository Bank Name	Depository Address

Bank Transit Number	Account Number

4. I agree to allow the COMPANY to stop payment or posting of, reverse or adjust any entry erroneously credited to my account.

5. This authorization is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and manner as to afford the COMPANY a reasonable opportunity to act on it.

Print Name	Title (if applicable)	Date
Signature		

Mail completed form with voided check to:
United HealthGroup
Deb Wisner, MN008-W235
9900 Bren Rd E
Minnetonka, MN 55343

OR

Email completed form with voided check to:
vendor_maint_ap@uhc.com

Please contact Deb Wisner with questions regarding this form at: (952) 936-6328