MedMutual PROTECT®
A Medical Mutual® Company

MedMutual Protect Service Center
P.O. Box 14327
Reading, PA 19612

Claimant Authorization for Claims Payment via Electronic Funds Transfer

This form is for individual claimants to authorize the initiation of direct deposit of claims payments via electronic fund transfer (EFT) to a bank account or to change bank account information for an existing authorization. This form is only for *individual* claimants.

Claimant's information: _____

Name as it appears on bank account

_____

Social Security Number

I authorize MedMutual Protect to electronically credit my account and, if necessary, electronically debit my account to correct erroneous credits. I agree that the Automated Clearing House transactions I authorize comply with all applicable law. I understand that the insured individual to whom benefits are payable under one or more MedMutual Protect policies must be named on the bank account provided for direct deposit.

Banking information:

_____

Name of Financial Institution

Account type: ☐ Checking ☐Savings

_____

Routing Number Account Number

I understand that (1) I may revoke this authorization at any time by notifying MedMutual Protect in writing at MedMutual Protect Service Center P.O. Box 14327, Reading, PA 19612; (2) MedMutual Protect requires prior notice of at least five business days to cancel this authorization; and (3) in the event I cancel direct deposit of claims payments, future claims payments will be made via paper check.

Note: A handwritten signature is required.

Insured's Signature exactly as it appears in bank records (claimant or legal representative):

_____ _____

Signature Date

Please return your completed authorization form with claim form via the portal https://medmutualprotect.loomislive.com, by fax to 610.374.6986, or by mail to the MedMutual Protect Service Center at P.O. Box 14327, Reading, PA 19612.