

ANTEX Direct Deposit Information

Have your client use these account numbers and routing numbers for their allotment.

It is best and most effective to make them use the MyPay system.

[Youtube How To: myPay](#)

[Youtube How to: Setting up myPay account \(if not already set up\)](#)

THEY DO NOT NEED TO SUBMIT THIS FORM. IT IS ONLY FOR THE INFORMATION. KEEP FOR YOUR RECORDS.

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (last, first, middle initial)		D TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS																		
ADDRESS (street, route, P.O. Box, APO/FPO)		E DEPOSITOR ACCOUNT NUMBER <table border="1" style="width: 100%; text-align: center;"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td>0</td><td>9</td><td>9</td><td>8</td><td>6</td><td>1</td><td>9</td><td>9</td><td>2</td><td>1</td><td>5</td> </tr> </table>								0	9	9	8	6	1	9	9	2	1	5
						0	9	9	8	6	1	9	9	2	1	5				
CITY	STATE	ZIP CODE																		
TELEPHONE NUMBER AREA CODE		F TYPE OF PAYMENT (Check only one)																		
B NAME OF PERSON(S) ENTITLED TO PAYMENT		<input type="checkbox"/> Social Security <input type="checkbox"/> Fed. Salary/Mil. Civilian Pay <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Mil. Active _____ <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Mil. Retire. _____ <input type="checkbox"/> Civil Service Retirement (OPM) <input type="checkbox"/> Mil. Survivor _____ <input type="checkbox"/> VA Compensation or Pension <input type="checkbox"/> Other _____ (specify)																		
C CLAIM OR PAYROLL ID NUMBER		G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (if applicable)																		
Prefix	Suffix	TYPE	AMOUNT																	
PAYEE/JOINT PAYEE CERTIFICATION		JOINT ACCOUNT HOLDERS' CERTIFICATION (optional)																		
I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.																		
SIGNATURE	DATE	SIGNATURE	DATE																	
SIGNATURE	DATE	SIGNATURE	DATE																	

SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION JP Morgan Chase Bank 712 Main Street Houston, TX 77002		ROUTING NUMBER <table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td><td>6</td><td>1</td><td>4</td> </tr> </table>		1	1	1	0	0	0	6	1	4
1	1	1	0	0	0	6	1	4				
DEPOSITOR ACCOUNT TITLE		CHECK DIGIT										
FINANCIAL INSTITUTION CERTIFICATION												
I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.												
PRINT OR TYPE REPRESENTATIVE'S NAME Christopher Davenport CSO	SIGNATURE OF REPRESENTATIVE <i>C. Davenport</i>	TELEPHONE NUMBER 713 216 5499	DATE 3/25/14									

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

E-Application

<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Case Information <input checked="" type="checkbox"/> Primary Insured <input checked="" type="checkbox"/> Primary Insured Cont. <input checked="" type="checkbox"/> USA Patriot Act <input checked="" type="checkbox"/> Product Information - Universal Life <input checked="" type="checkbox"/> Beneficiaries - Primary Insured <input checked="" type="checkbox"/> Existing Insurance and Replacements <li style="background-color: #0056b3; color: white;"><input checked="" type="checkbox"/> Premium Information <input checked="" type="checkbox"/> Physician Information - Primary Insured <input checked="" type="checkbox"/> Family History - Primary Insured 	Premium Information												
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Payment Mode</td> <td><input type="text" value="Bi-Weekly"/></td> </tr> <tr> <td>Payment Method</td> <td><input type="text" value="Salary Deduction"/></td> </tr> <tr> <td>Bi-Weekly Amount</td> <td><input type="text" value="\$ 60"/></td> </tr> <tr> <td>Amount paid with application</td> <td><input type="text" value="\$ 0"/></td> </tr> <tr> <td>Payor</td> <td><input type="text" value="Primary Proposed Insured"/></td> </tr> <tr> <td>Franchise Number</td> <td><input type="text" value="03000TX"/></td> </tr> </table>	Payment Mode	<input type="text" value="Bi-Weekly"/>	Payment Method	<input type="text" value="Salary Deduction"/>	Bi-Weekly Amount	<input type="text" value="\$ 60"/>	Amount paid with application	<input type="text" value="\$ 0"/>	Payor	<input type="text" value="Primary Proposed Insured"/>	Franchise Number	<input type="text" value="03000TX"/>
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Display on paper application

24. BILLING DATA	
a. Mode:	<input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Single premium
b. Method:	<input type="checkbox"/> Direct: <i>(Fill in name and address where premium notices are to be sent, ONLY IF OTHER than those of primary proposed insured.)</i>
	Name _____ Number/Street _____ City _____ State ZIP _____ Country _____
	<input type="checkbox"/> Electronic fund transfer (EFT): <i>(Complete "Electronic Fund Transfer" section 25 and attach a void check.)</i>
	<input checked="" type="checkbox"/> Salary deduction: Name _____ Number _____ Billing Selections _____ 03000TX
	<input checked="" type="checkbox"/> Biweekly Amount 60 _____
	<input type="checkbox"/> Government allotment: Payee name _____ <input type="checkbox"/> A. Copy of certified allotment attached to application <input type="checkbox"/> B. Certified copy of Form 902 completed in lieu of allotment copy <input type="checkbox"/> C. Cash with application – No allotment copy <input type="checkbox"/> D. C.O.D. – Defer issue until allotment begins.
	Rank _____ Branch _____ Social Security number _____ Special dating instructions: Issue age _____ Issue date _____