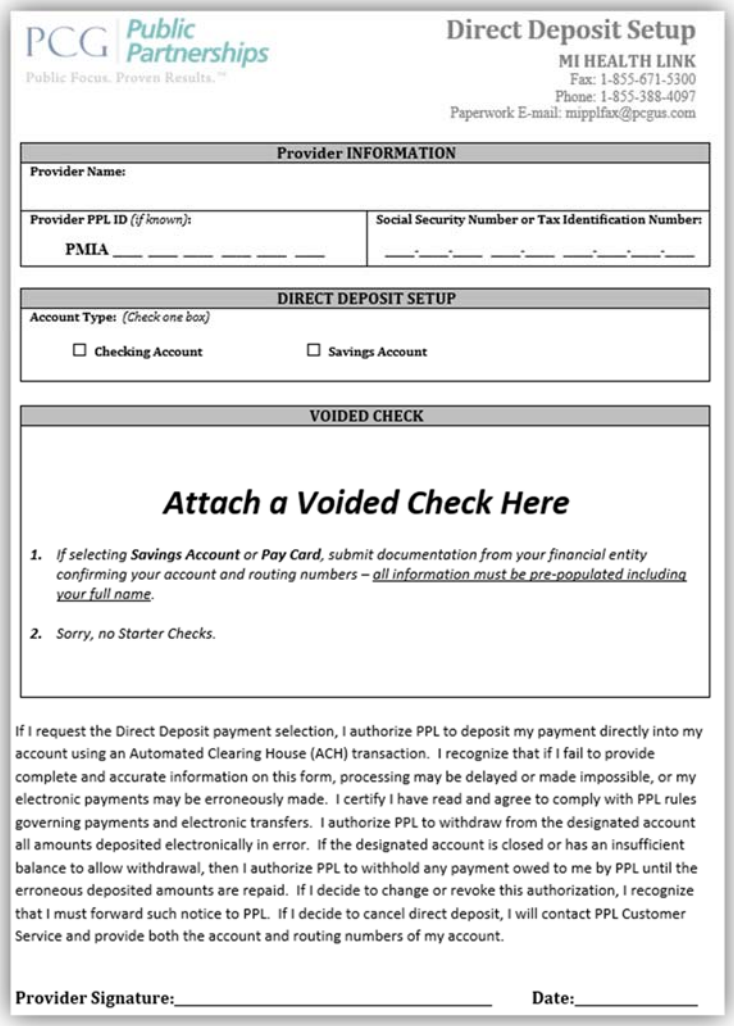
Public Partnerships, LLC
1 Cabot Road, Suite 102
Medford, MA 02155
Phone: 1-855-388-4097

Instructions for Direct Deposit Setup

What is the purpose of this form?

If an employee would like their payments made via Direct Deposit, they may fill out and submit this form to Public Partnerships, LLC (PPL).



PCG Public Partnerships
Public Focus. Proven Results.™

Direct Deposit Setup
MI HEALTH LINK
Fax: 1-855-671-5300
Phone: 1-855-388-4097
Paperwork E-mail: mipplfax@pcgus.com

Provider INFORMATION

Provider Name:

Provider PPL ID *(if known)*: PMIA ___ ___ ___ ___ ___ ___

Social Security Number or Tax Identification Number: ___-___-___ ___-___-___ ___-___-___-___

DIRECT DEPOSIT SETUP

Account Type: *(Check one box)*

☐ **Checking Account** ☐ **Savings Account**

VOIDED CHECK

Attach a Voided Check Here

1. *If selecting* ***Savings Account*** *or* ***Pay Card****, submit documentation from your financial entity confirming your account and routing numbers – all information must be pre-populated including your full name.*
2. *Sorry, no Starter Checks.*

If I request the Direct Deposit payment selection, I authorize PPL to deposit my payment directly into my account using an Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify I have read and agree to comply with PPL rules governing payments and electronic transfers. I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me by PPL until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to PPL. If I decide to cancel direct deposit, I will contact PPL Customer Service and provide both the account and routing numbers of my account.

Provider Signature:_____ **Date:**_____

How do I complete this form?

- Fill in your Name, PPL ID *(if known)*, and Social Security Number in the blanks at the top of the page.
- Check off the appropriate box indicating if the Direct Deposit is going to a Checking Account, Savings Account, or a Pay Card.
- Check off the "***Do NOT Send the Paper Remittance Advice…"*** box if you prefer to view your paystubs online.
- Attach a Voided Check to the form ***OR*** submit documentation from your financial entity confirming the account number and routing number of the account you wish the funds to be deposited into.
- Sign and Date the bottom of the form.

Where to send the form?

Fax	**E-mail**	**Mail**
1-855-671-5300	mipplfax@pcgus.com	Public Partnerships, LLC MI HEALTH LINK 1 Cabot Road, Suite 102 Medford, MA 02155

PCG Public Partnerships
Public Focus. Proven Results.™

Direct Deposit Setup

MI HEALTH LINK
Fax: 1-855-671-5300
Phone: 1-855-388-4097
Paperwork E-mail: mipplfax@pcgus.com

Provider INFORMATION	
Provider Name:	
Provider PPL ID *(if known)*: **PMIA** ____ ____ ____ ____ ____ ____	**Social Security Number or Tax Identification Number:** ____-____-____ ____-____ ____-____-____-____

DIRECT DEPOSIT SETUP

Account Type: *(Check one box)*

☐ **Checking Account** ☐ **Savings Account**

VOIDED CHECK

Attach a Voided Check Here

1. *If selecting **Savings Account** or **Pay Card**, submit documentation from your financial entity confirming your account and routing numbers – all information must be pre-populated including your full name.*
2. *Sorry, no Starter Checks.*

If I request the Direct Deposit payment selection, I authorize PPL to deposit my payment directly into my account using an Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify I have read and agree to comply with PPL rules governing payments and electronic transfers. I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me by PPL until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to PPL. If I decide to cancel direct deposit, I will contact PPL Customer Service and provide both the account and routing numbers of my account.

Provider Signature:_____ **Date:**_____