


WIRE AUTHORIZATION FORM

Supplier Name: _____ **Tax ID or Social Security Number:** _____
 (“Company/Party”) sells goods and/or services to Aetna, and/or one or more of its wholly-owned subsidiaries (herein collectively called “Aetna”)

Therefore, Party hereby (1) authorizes Aetna to make payments for goods and services by EFT, (2) certifies that it has selected the following depository institution and (3) directs that all such electronic funds transfers be made as provided below:

COMPANY (CORPORATE CHECKING ACCOUNT)	COMPANY PAYMENT DETAILS (SELECT ONE) How you will receive your payment details
Depository Bank Name: Address: City, State, Zip code: Bank Routing Number: Checking Acct Number:	CTX: <input type="checkbox"/> Electronic Format (Your Bank must have an electronic A/R system) Our bank sends the detail to your bank electronically, which in turn sends it to you electronically. CCP: <input type="checkbox"/> (choose an option below) <input type="checkbox"/> E-Mail Format: Our bank will e-mail the remittance detail to the e-mail address provided below: Sent by grsp-aetnaap@maf.xpedite.com E-mail address: _____ <input type="checkbox"/> Paper Remittance: Our bank will mail the remittance detail to the mailing address provided below. Supplier’s Address:

INDIVIDUAL (PERSONAL CHECKING ACCOUNT)	INDIVIDUAL PAYMENT FORMAT (Pre Authorized Pmt & Deposit, PPD)
Depository Bank Name: Address: City, State, Zip code: Bank Routing Number: Checking Acct Number:	Mailing Address for paper remittance: City, State, Zip code:

Company/Party will give thirty (30) days advance notice in writing to Aetna of any changes in its depository institution or other payment instructions. Failure to provide change notification will result in delayed payments. When properly executed, Authorization will become effective within fifteen (15) days after its receipt by Aetna.

 Signature of Company Representative/Individual

 Printed Name, Title Authorized Representative

 Date