

**HEALTHPLEX, INC.
BROKER AUTHORIZATION AGREEMENT
FOR DIRECT DEPOSIT**

I / We hereby authorize Healthplex, Inc. to initiate credit entries to my/our account indicated below at the depository bank named below, representing monthly commission payment. Debit charges to said account are not authorized, unless such charge represents a reversal of credit amounts erroneously posted by Healthplex, Inc.

I/We do not wish to participate in direct deposit at this time.

Broker Name _____

Authorized Signature(s) _____

Tax ID # _____ Date _____

Financial Institution: _____ City _____ State _____

Bank Routing No. _____

Bank Branch No. _____

For the account of: _____

Type of account: Check One

Checking Savings Money Market

Account # _____

***Please provide a voided check from your account listed above.
Direct Deposit cannot be processed without your check.***

This authorization is to remain in full force and effect until Healthplex, Inc. has received written notification from the undersigned of its termination in such time and in such manner as to afford Healthplex, Inc. and Depository bank a reasonable opportunity to act on it.

Please return completed form to the Commission Department at FAX # : **516-228-4829**

July, 2007