Utah Department of Health
eWIC Vendor Direct Deposit Form

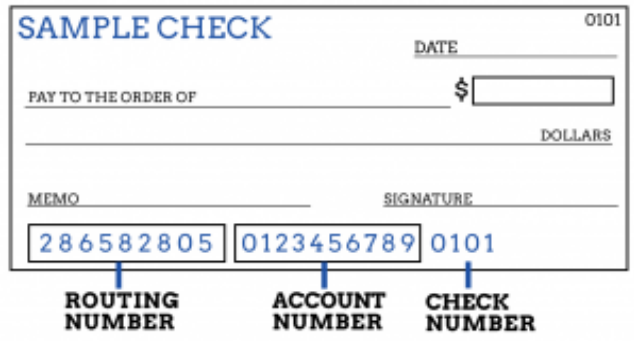
Vendor Name _____ Tax ID or SSN _____

Vendor Address _____
(Street)

_____
(City) (State) (Zip Code)

Remittance Contact _____

Remittance Email Address _____



Account Type

- ☐ Checking
- ☐ Savings
- ☐ Business - Corporate
- ☐ Business - Store
- ☐ Personal - Owner

Name of Bank _____

ABA/9-Digit Routing Number _____

Account Number _____

I declare all banking information provided herein is correct. I hereby approve and authorize the State of Utah, Department of Health, Special Supplemental Nutrition Program for Women, Infants and Children to electronically deposit payments to the account number above. This authorization will remain in effect until it is modified or cancelled in writing.

Authorized Signature _____

Printed Name _____ Date: _____