MassMutual Ascend
Life Insurance Company

DIRECT DEPOSIT OF COMMISSIONS AUTHORIZATION AGREEMENT (Required Form)

❑ I (we) hereby authorize MassMutual Ascend Life Insurance Company to *initiate* credit/deposit entries to my (our) account indicated below, and the depository institution named below to credit the same to such account.

❑ I (we) hereby request a *change* to my (our) existing direct deposit as indicated below.

Note: To avoid delays in processing your appointment, **a voided check must accompany this request**. Please allow 5 business days for EFT processing to become effective.

Frequency: ☐ **Daily** ☐ **Weekly** ☐ **Bi-weekly** ☐ **Monthly**

INDIVIDUAL AGENT INFORMATION - Please print or type		
Primary Name on Account	Social Security or Tax ID Number	Agent #
Address	City, State	Zip Code
Secondary Name on Account (Optional)	Phone Number	
DEPOSITORY INFORMATION - Please print or type		
Depository Name	Depository Address	Depository Phone Number
Account Number	Type of Account ☐ Checking ☐ Savings	Transit/ABA Number

This authorization is to remain in full force and effect until the Company has received written notification from me (or either of us) to discontinue direct deposit. Please allow 15 business days for processing of EFT discontinuation. This authorization may not be used to assign commissions and will not constitute a commission assignment. If you want to assign your commissions, please use form X2653814NW.

Attach a voided check and e-mail, fax or mail to:

MassMutual Ascend Life Insurance Company
P.O. Box 5420
Cincinnati, Ohio 45201-5420
Attn: Contracting
E-mail: AnnuityLicensing@mmascend.com
Fax: (513) 412-5144

Signature of Primary Account Holder _____ Date _____

E-mail Address (**Required**) _____

Signature of Secondary Account Holder (optional) _____ Date _____