18618

# Verification of Deposit

## Medical or Public Assistance Agencies

WELLS FARGO

**For faster processing, please complete the form on your computer before printing.**

**This form is for medical or public assistance agencies requesting consumer deposit information. Please complete the form including the customer authorization signature and fax to the number below. Your completed request will be faxed to the return fax number provided on this form.**

**TYPE or complete in BLACK INK. Use only CAPITAL LETTERS**

**Fax Request To Balance Confirmation Services.....1-844-879-0412**
**Online Instructions.....www.wellsfarwo.com/vod**

### SECTION 1: REQUESTER INFORMATION

Company Name

Attention

Street Address

City | State | Zip

Requester Email (optional)

Requester Phone Number

Return Fax Number

### SECTION 2: CUSTOMER INFORMATION

Customer One Full Name (First Middle Last)

Customer Two Full Name (First Middle Last)

Customer One Social Security Number

Account Number(s)

### CUSTOMER AUTHORIZATION

**I/We authorize and direct Wells Fargo Bank to release the following information to the above mentioned requestor on my deposit accounts listed above or if only a Social Security Number is provided, all open depository accounts: Account Number, Account Type, Open or Closed, Account Holder(s), Current/Closing Balance, Open/Close Date, Current Interest Rate, Previous Six Average Statement Balances and Previous Six Months Interest Paid. In addition, CDs and IRAs will include: Term, Maturity Date, Interest Payment, Interest Method and Penalty.**

**Signature of Account Holder** **Date** **Signature of Account Holder** **Date**