18618

Verification of Deposit
Medical or Public Assistance Agencies
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.

WELLS FARGO

TYPE or complete in BLACK INK. Use only CAPITAL LETTERS

Fax Request To Balance Confirmation Services..1-844-879-0412
Online Instructions..www.wellsfargo.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)

Account Number(s)

Customer One Social Security Number

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, Balance as of Specific Dates, 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.

Printed Name of Account Holder   Signature of Account Holder   Date

Printed Name of Account Holder   Signature of Account Holder   Date