DELTA DENTAL

ELECTRONIC FUNDS TRANSFER (EFT)/DIRECT DEPOSIT AUTHORIZATION AGREEMENT

For agent commissions, please complete and return this form to commissions@deltadentalmi.com
All others, complete and return to accountspayable@deltadentalmi.com

BUSINESS INFORMATION

Business Name _____

Business Address _____

Tax ID Number/SSN last four digits (whichever applies) _____

Phone Number_____Email Address _____

BANK OR FINANCIAL INSTITUTION INFORMATION PLEASE ATTACH A "VOIDED CHECK"

Select One: ❑ New Account ❑ Account Change ❑ Cancel Deposit

Name on Account _____

Name of Financial Institution _____

Routing Number (9 digits) _____

Checking Acct No _____ or Savings Acct No _____

AUTHORIZATION STATEMENT

By signing below, I request and authorize the Company stated above to deposit automatically to the checking or savings account stated in this authorization. I agree that each deposit the Company makes to this account will be a payment to individual or business listed on this document, without regard to the person or persons that may withdraw or receive funds from that account. Adjusting entries to correct errors are also authorized. This authority will remain in effect until I have canceled it in writing.

Signature of Authorized Account Holder _____

Printed Name _____

Date _____

FOR DELTA USE ONLY – Name of employee verifying _____

Name/Job title of verifier	
Phone number	Date of verification
Last 4 digits of prior account number	Follow up letter mailed
Last deposit amount	Filed without update date