AGENCY/BROKER ACH DIRECT PAYMENT AUTHORIZATION

ARE YOU A FIRST TIME PAYEE? IF SO, COMPLETE W-9 FORM ALONG WITH THIS FORM.

PLEASE CHECK ONE: ☐ **NEW** ☐ **CHANGE** ☐ **CANCEL**

PAYEE INFORMATION (Who is receiving payments):

NAME OF PAYEE: _____

ADDRESS: _____
Street City State Zip

PHONE: _____

EMAIL ADDRESS: _____

FEDERAL TAX IDENTIFICATION # OR SOCIAL SECURITY #: _____

FINANCIAL INFORMATION: (COPY OF VOID CHECK REQUIRED)

TYPE OF ACCOUNT ☐ Checking Account

Routing Number: _____

Account Number: _____

Financial Institution Name: _____

Address: _____

City: _____ State: _____ Zip: _____

AUTHORIZATION:

☐ I hereby authorize Delta Dental of Minnesota to provide direct payment of any commission, invoice or reimbursement due to me in to the above designated account.

If, at any time, the amount of payment so deposited exceeds the amount of payment actually due and payable to me, I hereby authorize Delta Dental of Minnesota at its discretion to either withhold a sum equal to the overpayment from future payments or recover such overpayment from the above-designated account

If any action taken by me results in non-acceptance of a direct payment by the designated financial institution, I understand that Delta Dental of Minnesota assumes no responsibility for processing a supplemental payment until the amount of the non-accepted deposit is returned to Delta Dental of Minnesota by the financial institution.

_____ _____
Printed Name Title

_____ _____
Signature Date

RETURN COMPLETED FORM TO:

Email: DDMNbroker@deltadentalmn.org
Fax: **1.855.354.4746**
Toll Free: **1.855.648.1409**
Website www.deltadentalmn.org

Mail To:
Delta Dental of Minnesota
Attn: Commissions
500 Washington Ave S, Suite 2060
Minneapolis, MN 55415