





Delta Dental of Minnesota
P. O. Box 9304
Minneapolis, MN 55440-9304

**Automated Clearinghouse
Authorization Agreement
Commissions Department Only**

Delta Dental of Minnesota is hereby authorized to credit our bank account through the Automated Clearinghouse (ACH) for the **Total Amount Owed** according to the monthly **commissions** statement. The pre-authorized deposits are generally made by the fifth (5th) business day of the following month.

Broker/Agency Name	_____
Delta Dental Vendor Number (located in the upper right hand corner of the check stub)	<input type="text"/>

ACH Effective Date	_____
Bank Name	_____
Bank Address	_____
Bank Account Number	_____
Type of Account	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank Account Name	_____
Bank Routing Number	_____
	(between these symbols   on the bottom left of your check)
PLEASE INCLUDE A VOIDED CHECK	

Authorized individual of the Account	_____
	Print
	Signature
	Today's Date
	Title
	Telephone Number

If you have any questions, please call **Delta Dental's Commissions Department**. Upon completing this form, please mail or fax it along with a copy of a voided check to (651) 406-5934 or toll-free to (877) 201-7345.

Or mail to: Delta Dental of Minnesota
ATTN: Commissions Department
3560 Delta Dental Drive
Eagan, MN 55122-3166

Commissions Department (651) 406-5900
toll-free: 1-(800) 328-1188
toll-free: 1-(877) 631-8953
toll-free: 1-(877) 201-7345