



Self-Insured Groups

Automated Clearinghouse Authorization Agreement

Company Name _____

authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the **Total Amount Due** according to our Invoice / Statement. If billed monthly, ACH will be taken on the 10th of each month. If the 10th is a weekend or holiday, ACH will be taken the next business day. If billed weekly, ACH will be taken two (2) business after the invoice has been delivered/mailed.

Group Number _____

ACH Effective Date _____

Bank Name _____

Bank Address _____

Bank Account Number _____

Type of Account Checking 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

E:Mail address

Questions? Please call our Billing and A/R Department at: 651-406-5902 or 1-800-906-4702

Please complete this form and fax to us at: 651-406-5934 or 1-877-201-7345.

or,

Please complete this form and mail to:

Delta Dental of Minnesota
ATTN: Billing and Accounts Receivable
P.O. Box 9304
Minneapolis, MN 55440-9304