



Fully-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. Premium will be taken
on the first business day of each month.
Group Number _____

ACH Effective Date _____
Bank Name _____
Bank Address _____
Bank Account Number _____
Type of Account [] Checking [] Savings
Bank Account Name _____
Bank Routing Number _____
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