DELTA DENTAL

Delta Dental of Minnesota

DIRECT DEBIT AUTHORIZATION
VIA ACH (Automatic Withdrawals)

Client Name: _____

Client Number: _____

Client Sub-location Number(s): _____

Effective Date: _____

Financial Institution Information:

Bank Name: _____

Bank Address: _____

ABA (Routing) Number: _____

Account Number: _____

Type of Account: _____

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above in accordance with my underlying contract with Delta Dental and Delta Dental's ACH processing policies. I understand that I am responsible for any fees incurred due to the ACH being rejected or returned for any reason by my bank and collection action may be taken.

This authorization will remain in full force and effect until Delta Dental has received written notification from me of its termination in such time as to afford Delta Dental and the Financial Institution a reasonable opportunity to act on it, or until all of my payment obligations under the contract have been satisfied.

Should you have any questions regarding your Direct Debit (ACH) Instructions, please contact the Accounting Department at 1.800.906.4702 or AR@deltadentalmn.org

Mailing address: 500 Washington Avenue So, Suite 2060, Minneapolis, MN 55415

Office hours are Monday through Friday, 8 a.m. to 5 p.m. CST.

Authorized Signature: _____ Date: _____

Printed Name: _____ Phone Number _____