DELTA DENTAL®

Authorization For Direct Deposit of Commission Checks

SECTION A INSTRUCTIONS

Please complete Sections B, C and D and return this Authorization For Direct Deposit of Commission Checks along with a Deposit Slip or "VOIDED" check to the following address or fax:

Accounts Payable
Delta Dental of Michigan, Ohio & Indiana
P.O. Box 30416
Lansing, MI 48909-7916

Fax: 517-381-5573

SECTION B BUSINESS INFORMATION

(PLEASE TYPE OR PRINT)

Agency/Agent Name _____

Tax ID Number/SSN Last Four Digits (whichever applies) _____ Phone Number (____) _____

Address _____ City_____ State ____ ZIP Code _____

SECTION C BANK OR FINANCIAL INSTITUTION INFORMATION

PLEASE ATTACH A DEPOSIT SLIP OR "VOIDED" CHECK

Check One ❑ New Account ❑ Account Change ❑ Cancel Deposit

Name of Account (as it appears on savings/checking account) _____

Bank or Financial Institution Name _____

Address _____ City _____ State ____ ZIP Code _____

Phone Number (____) _____ Routing Number _____

Type of Account ❑ Savings Account No. _____ ❑ Checking Account No. _____

ATTACH DEPOSIT SLIP ATTACH "VOIDED" CHECK

SECTION D AUTHORIZATION STATEMENT

By signing below, I request and authorize the Delta Dental stated in Section A to deposit automatically to the checking or savings account stated in Secton C. I agree that each deposit Delta Dental makes to this account will be a payment to me, without regard to the person or persons that may withdraw or receive funds from that account. Adjusting entries to correct errors is also authorized. This authority will remain in effect until I have canceled it in writing.

_____ _____

Signature of Authorized Account Holder Date Signed

RETAIN A COPY OF THIS COMPLETED AGREEMENT FOR YOUR RECORDS