DELTA DENTAL

Direct Deposit Authorization: Broker/Agent

Electronic Funds Transfer (EFT) AUTHORIZATION AGREEMENT FOR COMMISSION PAYMENTS

I (we) hereby authorize Delta Dental of Arizona, Inc. to initiate credit (deposit) entries to my (our) indicated account at the financial institution named below:

Business Information			
Business Name		Tax ID Number	
Business Address	City	State	Zip
Business Contact Name	Business Contact Phone		
Authorized Account Holders Name	Email of Contact to Receive EFT Statement		

Bank Information	
Name of Financial Institution	Account Name (If applicable)
Contact Person (If applicable)	Contact Phone
Bank Routing Number	
Account Number	☐ Savings ☐ Checking

Delta Dental of Arizona will keep all financial information secure and confidential

Authorization	
Print Name of Authorized Account Holder	Title
_____ Signature of Authorized Account Holder	_____/_____/_____ Date

This authorization is to remain in full force and effect until Delta Dental of Arizona, Inc. and said financial institution have received written notification from me of its termination in such time and in such manner to afford Delta Dental of Arizona and said financial institution a reasonable opportunity to act upon it.

I understand that any EFT transactions that are dishonored by my financial institution intended for payment to Delta Dental of Arizona may be assessed a $25 service charge.

Submission
Please email, fax, and or mail the completed application and EFT authorization to:

Delta Dental of Arizona
14850 N. Scottsdale Rd., Suite 400
Scottsdale, AZ 85254
Email: sales@deltadentalaz.com
Fax: 602.588.3921