



Automatic Draft Authorization

Please print or type when completing this form.

For Delta Dental internal use only	
Change Effective Date	____/____/____

Purpose of authorization:

- New Authorization**
- Changes to Existing Authorization** (Note: changes completed within 30 days of receipt of this form)

Name of company _____

Group Number _____

Address _____

City, State, Zip _____

Contact Name _____

Phone Number _____ Fax Number _____

E-mail Address _____

For Self-Funded Groups Only

The automatic draft applies to:

- Administrative Fees Only**
- Administrative Fees + Claims Payment**

Method to receive summary invoice:

- E-mail** **Fax**

Monthly eligibility listing?

- Yes** **No**

I (we) hereby authorize Delta Dental of Colorado hereinafter called "Company", to initiate debit entries from our account indicated below and the bank named below. I understand that employer groups eligibility can be placed on hold for a rejected draft. I also understand that this specified account would be deducted no later than 48 hours after a claims premium invoice is faxed to the group contact.

Account Type: **Checking** **Savings**

Name of Financial Institution: _____

Branch: _____

Transit/ABA Number (routing number): _____

Account Number: _____

This authority is to remain in full force and effect until Company has received notification from us of termination in such a time and such a manner as to afford Company and Bank a reasonable opportunity to act on it.

Authorized on Behalf of: _____

Printed Name: _____

Signature: _____

Date: _____