



# Delta Dental of Colorado- Wire Transfer Payment Authorization

*Please print or type when completing this form.*

Purpose of Authorization (please indicate one)

\_\_\_\_ New Authorization

\_\_\_\_ Changes to Existing Authorization *(Note: Changes will be completed within 30 days of receipt date)*

Name of Company: \_\_\_\_\_

Group Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

Name of Depositor: \_\_\_\_\_

DELTA DENTAL OF COLORADO, hereinafter called "COMPANY", authorizes the above listed employer group to initiate wire transfer payments into the COMPANY account indicated below and the BANK named below. I understand that employer group eligibility can be placed on hold for failure to send timely claims or premium payments

Wire payments should be initiated to the following account:

Type of Account: Delta Dental of CO Depository/Funding Account  
Name of Financial Institution: Wells Fargo  
Branch: Monaco  
Transit/ABA No: #102000076  
Account No: #2408016005

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

Authorized on behalf of: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Fax this form to (303) 221-4457, attn.: Accounts Receivable*