DELTA DENTAL

Automatic Draft Authorization Form
For employer groups

Please complete the form and return it to the address listed below.

○ New authorization

○ Changes to existing authorization (changes will be completed within 10 days of receipt of this form)

Group Information

Group Name:	Group Number:
Contact Name:	Phone:
Fax:	Email:

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 sent to the group contact.

Account Information

Account Type:	○ Checking ○ Savings
Financial Institution:	Branch:
Transit ABA Number (Routing Number):	
Account Number:	

Authorized Representative Signature:	
Name:	Date:

Self-Funded Groups Only

Please automatically draft:

- ○ Administrative fees only
- ○ Claims only
- ○ Administrative fees + claims payment

Please return this completed form as part of the New Group Application and Enrollment Packet to salesteam@ddpco.com. See the cover sheet for all the required forms.

Delta Dental of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com