

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	Financial Institution:
Savings	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 Representative Signature:**

**Name:**

**Date:**

Self-Funded Groups Only
Please automatically draft: Administrative fees only Administrative fees + claims payment

**Please return this completed form as part of the new group application and enrollment packet to [salesteam@ddpco.com](mailto:salesteam@ddpco.com). See the cover sheet for all the required forms.**