DELTA DENTAL®

Electronic Funds Transfer (EFT) Authorization: Group Dental/Vision Plans

EFT AUTHORIZATION AGREEMENT FOR PREMIUM PAYMENTS

I (we) hereby authorize Arizona Dental Insurance Service Inc., dba Delta Dental of Arizona, to initiate debit (withdrawal) entries and to initiate, if necessary, credit entries and adjustments for any debit (withdrawal) entries in error to my account and the financial institution indicated below:

Group Information	
Group Name	
Federal Tax ID Number	Group Number
Group Contact Name	Group Contact Phone Number
Email of Contact to Receive EFT Statement	

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

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

Authorization	
Name	Name
_____ Authorized Signature _____/_____/_____ Date	_____ Authorized Signature _____/_____/_____ Date

This authorization is to remain in full force and effect until Delta Dental of Arizona 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 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.
Scottsdale, Suite 400, AZ 85254
Email: billing@deltadentalaz.com
Fax: 602.548.5071