



Delta Dental of Nebraska  
P. O. Box 9304  
Minneapolis, MN 55440-9304

**Automated Clearinghouse  
Authorization Agreement  
Commissions Department Only**

Delta Dental of Nebraska is hereby authorized to credit our bank account through the Automated Clearinghouse (ACH) for the **Total Amount Owed** according to the monthly **commissions** statement. The pre-authorized deposits are generally made by the fifth (5th) business day of the following month.

Broker/Agency Name _____
Delta Dental Vendor Number (located in the upper right hand corner of the check stub) <span style="border: 1px solid black; display: inline-block; width: 100px; height: 20px; vertical-align: middle;"></span>

ACH Effective Date _____
Bank Name _____
Bank Address _____
Bank Account Number _____
Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank Account Name _____
Bank Routing Number _____ (between these symbols  on the bottom left of your check)
<b>PLEASE INCLUDE A VOIDED CHECK</b>

Authorized individual of the Account	_____
Print	_____
Signature	_____ Today's Date
Title	_____ Telephone Number

If you have any questions, please call *Delta Dental's Commissions Department*. Upon completing this form, please mail or fax it along with a copy of a voided check to (651) 406-5934 or toll-free to (877) 201-7345.

**Or mail to:** Delta Dental of Nebraska  
**ATTN: Commissions Department**  
3560 Delta Dental Drive  
Eagan, MN 55122-3166

**Commissions Department** (651) 406-5900  
toll-free: (800) 328-1188  
  
Fax: (651) 406-5934  
toll-free: (877) 201-7345