

## Fully-Insured Groups

### Automated Clearinghouse Authorization Agreement

Company Name \_\_\_\_\_

authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the **Total Amount Due** according to our Invoice / Statement. Premium will be taken on the first business day of each month.

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

ACH Effective Date \_\_\_\_\_

Bank Name \_\_\_\_\_

Bank Address \_\_\_\_\_

Bank Account Number \_\_\_\_\_

Type of Account  Checking  Savings

Bank Account Name \_\_\_\_\_

Bank Routing Number \_\_\_\_\_

(between these symbols  on the bottom left of your check)

**PLEASE INCLUDE A VOIDED CHECK**

Authorized individual of the Account \_\_\_\_\_

Print \_\_\_\_\_

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

E:Mail address \_\_\_\_\_

Questions? Please call our Billing and A/R Department at: 651-406-5902 or 1-800-906-4702

Please complete this form and fax to us at: 651-406-5934 or 1-877-201-7345.

or,

Please complete this form and mail to:

**Delta Dental of Nebraska**  
**ATTN: Billing and Accounts Receivable**  
**P.O. Box 9304**  
**Minneapolis, MN 55440-9304**