REQUEST FOR CANCELLED CHECK COPIES

Delta Dental has received your request for copies of cancelled check(s). To begin processing your request, however, we require a ***$10.00 administrative fee for <u>each</u> check you have requested***. Please mail the attached form with your check or money order made payable to Delta Dental and send it to:

Delta Dental
ATTN: Accounting, Check Copy Request
PO Box 30416
Lansing, MI 48909

We will begin the process of obtaining the cancelled check(s) you have requested as soon as we receive the attached form along with your payment. We will forward the copies to you once we have obtained them. Please allow one to two weeks for processing.

Thank you,
Delta Dental Accounting

DELTA DENTAL®

www.deltadentalmi.com
www.deltadentaloh.com
www.deltadentalin.com

Contact Information:

Contact Name: _____

Phone Number: _____

Email Address: _____

Anticipated reason for copy of check request:

☐ Embezzlement / Fraud
☐ Breach
☐ Reconcile Account
☐ Personal

Method desired to receive check copies:

☐ Paper mail to: _____

_____

☐ Email (if different then above please specify) _____

Please indicate on the schedule below the check(s) you would like to receive:

Cancelled Check Bank Acct#	Issue Date	Cashed Date	Check #	Check Amount