



# Automatic Draft Authorization

Please print or type when completing this form.

For Delta Dental internal use only

Change Effective Date

\_\_\_\_/\_\_\_\_/\_\_\_\_

Purpose of authorization:

- New Authorization**
- Changes to Existing Authorization** (Note: changes completed within 30 days of receipt of this form)

Name of company \_\_\_\_\_

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

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Contact Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

## For Self-Funded Groups Only

The automatic draft applies to:

- Administrative Fees Only**
- Administrative Fees + Claims Payment**

Method to receive summary invoice:

- E-mail**     **Fax**

Monthly eligibility listing?

- Yes**     **No**

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 faxed to the group contact.

**Account Type:**     **Checking**     **Savings**

**Name of Financial Institution:** \_\_\_\_\_

**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 on Behalf of:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please fax this completed form to 303-773-3880, or e-mail it to membershipacctg@ddpco.com.