

Group Authorization for Direct Payment via ACH

Delta Dental of South Dakota PO Box 1157 Pierre, SD 57501 (605)224-7345 Fax (605)224-0909 (800)627-3961 www.deltadentalsd.com

Group name:	Group #:	Loc #:
Name:		
Address:		
City/State/Zip:	Phone number:	
Email address:		
Direct payment via ACH is the transfer of f payment.	unds from a consumer account for the	e purpose of making a
Check one : ☐ Begin payment effective	□ Change information e	ffective
I authorize Delta Dental of South Dakota to electronically credit my account to correct on or around the 10th of each month.		
Select one : ☐ Checking account or ☐ Savbelow ("Depository"). I agree that ACH tra	. ,	
Depository name:		
Routing number:	Account number:	
Name on the account:		
I agree as the receiver of this authorized e that this authorization will remain in full for wish to revoke this authorization.		_
Printed name:		
Signature:	Date:	