Group Authorization for Direct Payment via ACH

Delta Dental of South Dakota
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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 funds from a consumer account for the purpose of making a payment.

Check one: ☐ Begin payment effective _____ ☐ Change information effective _____

I authorize Delta Dental of South Dakota to electronically debit my account and, if necessary, to electronically credit my account to correct erroneous debits. Funds will be drawn from your account on or around the 10th of each month.

Select one: ☐ Checking account or ☐ Savings account at the depository financial institution named below ("Depository"). I agree that ACH transactions I authorize comply with the laws of the United States and all applicable law.

Depository name: _____

Routing number: _____ **Account number**: _____

Name on the account: _____

I agree as the receiver of this authorized entry to be bound by the Nacha Operating Rules. I understand that this authorization will remain in full force and effect until I notify Delta Dental, in writing, that I wish to revoke this authorization.

Printed name: _____

Signature: _____ Date: _____