



Automatic Draft Authorization (ACH)
Please print or type when completing this form.

Purpose of Authorization (please indicate one)

New Authorization
 Changes to Existing Authorization
(Note: Changes will be completed within 30 days of receipt date)

Name of Company _____
Group Number _____
Address _____
City, State, Zip _____
Contact Name _____
Phone Number _____ Fax No _____
E-mail Address _____
Name of Depositor _____

Preferred Method to Receive Summary Invoice FAX E-mail
In addition to the summary invoice, do you wish to
receive a complete eligibility list each month? YES NO

For Self-funded Groups Only

The automatic draft applies to: Administrative Fees Only
 Claims Payment Only
 Administrative Fees & Claims Payment

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 group 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 or premium invoice is faxed to the group contact.

Type of Account: Checking Savings
Name of Financial Institution _____
Branch _____
Transit/ABA No _____
Account No _____

This authority is to remain in full force and effect until COMPANY has received notification from us of termination in such a time and in such a manner as to afford COMPANY and BANK a reasonable opportunity to act on it.

Authorized on behalf of _____
Printed Name _____
Signature _____
Date _____

Fax this form to (303) 221-4457, ATTN: Accounts Receivable