

# Electronic Funds Transfer (EFT) Authorization

(Required for small groups with 2-9 eligible employees)

Dental Care Plus, Inc. sells goods and/or services to \_\_\_\_\_ (Company).

Dental Care Plus, Inc. desires the flexibility to invoice and withdrawal monies for such goods and/or services by electronic funds transfer ("EFT") through the automated clearing house system and \_\_\_\_\_ (Company) agrees to grant such flexibility.

Therefore, \_\_\_\_\_ (Company) thereby (1) authorizes Dental Care Plus, Inc. to withdrawal monies for goods and/or services by EFT, (2) certifies that it has selected the following depository institution and (3) directs that all such electronic funds transfers be made as provided below:

**Depository Institution:** \_\_\_\_\_

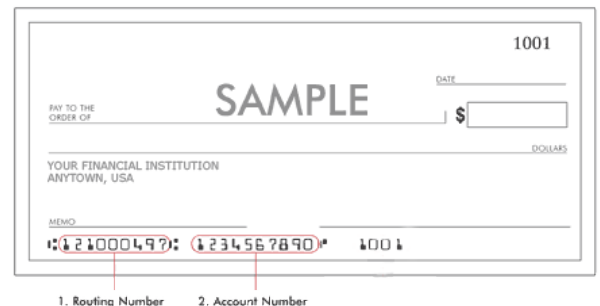
**Address:** \_\_\_\_\_

**Bank Routing No.:** \_\_\_\_\_

**Account Name:** \_\_\_\_\_

**Account Number:** \_\_\_\_\_

**Account Type:**      Checking      Savings



**Company EFT Contact:** \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_ (Company) will give thirty (30) days advance notice in writing to Dental Care Plus, Inc. of any changes in its depository institution or other payment instructions.

\_\_\_\_\_  
(Print Name of Authorized Representative)

\_\_\_\_\_  
(Signature of Authorized Representative)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

**\*PLEASE NOTE: THIS FORM AUTHORIZES THE DENTAL CARE PLUS GROUP TO DEDUCT THE MONTHLY PREMIUM FROM THIS ACCOUNT.**