



**Self-Insured Groups
Automated Clearinghouse Authorization Agreement**

Company Name _____

authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the **Total Amount Due** according to our Invoice / Statement. If billed monthly, ACH will be taken on the 10th of each month. If the 10th is a weekend or holiday, ACH will be taken the next business day. If billed weekly, ACH will be taken two (2) business after the invoice has been delivered/mailed.

Group Number _____

ACH Effective Date _____



Bank Name _____

Bank Address _____

Bank Account Number _____

Type of Account Checking Savings

Bank Account Name _____

Bank Routing Number _____
(between these symbols   on the bottom left of your check)

PLEASE INCLUDE A VOIDED CHECK

Authorized individual of the Account _____

Print _____

Signature _____ Today's Date _____

Title _____ Telephone Number _____

Please complete this form and mail to:

**DeCare Dental
PO Box 29
Minneapolis, MN 55440-0029
Attn: Billing and Accounts Receivable**