



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