DeCare Dental℠

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