

Automatic Draft Authorization for Administrative Services Only Groups

Purpose of Authorization (select one)

- New Authorization
- Changes to existing authorization (**Note:** Changes will be completed within 30 days from date of receipt)

Please print or type when completing this form.

Name of Company: _____

Group Number: _____

Address: _____

Phone Number: _____

Name of Depositor: _____
(Print name exactly as it appears on Financial Institution records)

Name of Financial Institution: _____ Branch: _____

Address: _____

Phone Number: _____

Account Type: Checking Savings

Claims Reimbursement

Monthly Administrative Fee

I (We) hereby authorize Delta Dental of Oklahoma (DDOK) and the financial institution named above to begin deductions of company claims reimbursements and/or administrative fees from the account I have indicated herein. I understand company claims can be placed on hold for a rejected draft.

Authorized Group Contact (please print) Title Date

Signature* Date

Note: A voided check must be attached to this authorization to process intended application.

Drafts occur a minimum of two (2) days after the claims and/or administrative fee invoices are issued.

*Signature must be that of an authorized signer on the account.

Email this form with a voided check to: Accounting@DeltaDentalOK.org

Or mail this form with a voided check to: Delta Dental of Oklahoma
Attn: Finance
P.O. Box 54709
Oklahoma City, OK 73154-1709