DELTA DENTAL

Automatic Draft Authorization

DELTA DENTAL OF OKLAHOMA

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: _____ Fax Number: _____

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

Name of Financial Institution: _____ Branch: _____

Address: _____

Phone Number: _____

Type of Account: ☐ Checking ☐ Savings

I (We) hereby authorize Delta Dental of Oklahoma and the financial institution named above to begin deductions of company dental premium from the account I have indicated herein. I understand that company eligibility can be placed on hold for a rejected draft. I also understand that this specified account would be deducted on the 5th day of each month.*

Print Name: _____

Signature: ** _____ Date: _____

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

Email this form with a voided check to: Accounting@DeltaDentalOK.org
-OR-
Fax this form with a voided check to: 405-241-0680
-OR-
Mail this form with a voided check to: Delta Dental of Oklahoma
Attn: Finance
P.O. Box 54709
Oklahoma City, Oklahoma 73154-1709

* If the 5th of the month falls on a weekend or holiday, Delta Dental of Oklahoma will debit the specified account on the next business day.
** Signature must be that of an authorized signer on the bank account.