DELTA DENTAL

Automatic Deposit Authorization Form

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)

Name of Producer/Agency

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 (Select One): ☐ **Checking** ☐ **Savings**

I (We) hereby authorize Delta Dental of Oklahoma and the financial institution named above to begin initiating credit entries of dental plan commissions to the account indicated herein.

Print Name

Signature* **Date**

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

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

Fax this form with a voided check to: **405-241-0680**

Mail this form with a voided check to:
Delta Dental of Oklahoma
Attn: Accounting
PO Box 54709
Oklahoma City, OK 73154-1709