



Delta Dental of Arizona

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize Delta Dental of Arizona to initiate debit entries the first week of the month and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account and the financial institution indicated below:

Name of financial institution

City, State, ZIP

Transit/Routing Number

Account Holder's Name

Account Number

Type of Account: Checking Saving

Attach a voided check here. ►

This authority is to remain in full force and effect until Delta Dental has received written notification from me of its termination in such time and in such manner to afford Delta Dental and financial institution a reasonable opportunity to act upon it.

Please Print Applicant Name

Phone Number

Applicant Signature

Date

Applicant Social Security Number

Employer Name

Please return your down payment, enrollment form, and this completed form to:

**Delta Dental of Arizona
P.O. Box 43000
Phoenix, AZ 85080**