



ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

(Required for small groups with 2-9 eligible employees)

Dental Care Plus, Inc. sells goods and/or services to _____(*Company*). Dental Care Plus, Inc. desires the flexibility to invoice and withdrawal monies for such goods and/or services by electronic funds transfer (“EFT”) through the automated clearing house system and _____(*Company*) agrees to grant such flexibility.

Therefore, _____(*Company*) thereby (1) authorizes Dental Care Plus, Inc. to withdrawal monies for goods and/or services by EFT, (2) certifies that it has selected the following depository institution and (3) directs that all such electronic funds transfers be made as provided below:

Depository Institution:	_____
Address:	_____
Bank Routing No.:	_____
Account Name:	_____
Account Number:	_____
Account Type:	_____ Checking _____ Savings
Company EFT Contact:	_____
Phone:	_____
Fax:	_____

_____(*Company*) will give thirty (30) days advance notice in writing to Dental Care Plus, Inc. of any changes in its depository institution or other payment instructions.

(Signature of Authorized Representative)

(Print Name of Authorized Representative)

(Title)

(Date)

***PLEASE NOTE: THIS FORM AUTHORIZES THE DENTAL CARE PLUS GROUP TO DEDUCT THE MONTHLY PREMIUM FROM THIS ACCOUNT.**