



# Automated Clearinghouse (ACH) Transfer of Funds For Fully-Insured Groups

Automated clearinghouse (ACH) transfer of funds is a safe, easy and effective way to ensure proper funding of your group's account. Your completion of this form will allow us to set up your ACH transfer. **Please return the form to our office within five working days.** If you prefer, you may fax the completed form to the Enrollment/Billing Department at 715-343-7609.

The ACH transfer for your group premium will occur monthly. An e-mail or fax will be sent to the contact person you designate around the 15th of each month, providing the total amount to be withdrawn from your bank on the first business day of the following month. You may be charged a small fee by your bank for the ACH transfer.

In addition to the monthly ACH notification, you will receive a monthly billing invoice that details premium adjustments and the current billed for that month. The invoice can be delivered online through our Employer Connection, or you can receive a paper copy by mail.

Please call Delta Dental's Enrollment/Billing Department if you have any questions regarding the information in this form.

Delta Dental of Wisconsin  
P.O. Box 828  
2801 Hoover Road  
Stevens Point, WI 54481  
800-236-3713  
Fax: 715-343-7609

## Automated Clearinghouse Authorization Agreement for Preauthorized Payments

I (we) hereby authorize Delta Dental of Wisconsin, Inc., hereinafter called Company, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account and the financial institution indicated below, herein called Depository, to debit and/or credit the same such account.

\_\_\_\_\_  
Group Name

\_\_\_\_\_  
Federal Tax ID Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Contact Person (to receive the monthly notification)

\_\_\_\_\_  
Contact Person's Phone

\_\_\_\_\_  
Contact Person's E-Mail

\_\_\_\_\_  
Contact Person's Fax

Notification Preference:  E-mail  Fax

\_\_\_\_\_  
Depository Name

\_\_\_\_\_  
Depository Transit/ABA Number

\_\_\_\_\_  
Account Name

\_\_\_\_\_  
Account Number

Savings or  Checking?

\_\_\_\_\_  
Depository Contact Person

\_\_\_\_\_  
Depository Contact Person's Phone

This authority is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date