



Delta Dental of North Carolina
 P. O. Box 9304
 Minneapolis, MN 55440-9304

**Automated Clearinghouse
 Authorization Agreement
 Commissions Department Only**

Delta Dental of North Carolina is hereby authorized to credit our bank account through the Automated Clearinghouse (ACH) for the **Total Amount Owed** according to the monthly commissions statement. The pre-authorized deposits are generally made by the fifth (5th) business day of the following month.

Broker/Agency Name _____
Delta Dental Vendor Number (located in the upper right hand corner of the check stub)

ACH Effective Date _____
Bank Name _____
Bank Address _____
Bank Account Number _____
Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank Account Name _____
Bank Routing Number _____ <small>(between these symbols on the bottom left of your check)</small>
PLEASE INCLUDE A VOIDED CHECK

Authorized individual of the Account	_____
Print	_____
Signature	_____ Today's Date
Title	_____ Telephone Number

If you have any questions, please call *Delta Dental's Commissions Department*. Upon completing this form, please mail or fax it along with a copy of a voided check to (651) 406-5934 or toll-free to (877) 201-7345.

Or mail to: Delta Dental of North Carolina
 ATTN: Commissions Department
 3560 Delta Dental Drive
 Eagan, MN 55122-3166

Commissions Department (651) 406-5900
 toll-free: (800) 328-1188
 Fax: (651) 406-5934
 toll-free: (877) 201-7345