



Fax: (954) 923-2694

Email: MSturgill@DentalPlans.com

## ELECTRONIC PAYMENT AUTHORIZATION

Affiliate ID #: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

### Bank Account Information:

Account Holder: \_\_\_\_\_

Financial Institution Name: \_\_\_\_\_

Nine digit ABA Routing #: \_\_\_\_\_

Account #: \_\_\_\_\_

I authorize DentalPlans.com to remit my commission electronically to the account named above. If I choose to discontinue this method of payment, I will notify DentalPlans.com in writing.

\* Please take note that the checking account will have to go through the pre-notification process with the bank to ensure the account is active and correct which can take one full payroll cycle. You may receive a check until this process is complete.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

