



A Registered Mark of Delta Dental Plans Association



**Initial Premium Authorization Form**  
**(First Payment Only)**  
**New Account Automated Clearing (ACH) Payment Authorization**

**A. Business Information**

Business Name
---------------

**B. Contact Information**

Contact Name		Primary Contact Phone Number	
Contact Street Address			
City	State	Zip Code	Country
Email Address		Secondary Contact Phone Number	

**C. Premium Information**

Initial Premium Amount (\$)
-----------------------------

**D. Bank Account Information**

Bank Account Type <i>(Checking / Savings)</i>	
Name on the Account <i>(This must match the name as it appears on an actual check)</i>	
ABA Transit Routing number <i>(The first nine digits found on the bottom left of a check)</i>	
Bank Account Number <i>(The number of the bottom right of the check)</i>	

**E. Authorization of Payment**

<p>I understand that by completing this form, I am authorizing Delta Dental and/or Delta's authorized representative to withdraw this and only this FIRST INITIAL PAYMENT for the amount listed above from the bank account I have provided on this form. <b>This is a one-time authorization for the First Month premium only.</b></p> <p>I understand that this payment will be deducted from the account I have provided within one to two business days AFTER NOTIFICATION that our group Dental plan has been approved. This approval will be sent to my agent by Delta.</p>	
Name of Person Authorized to Send Payment <i>(please print)</i>	Signature of Person Authorized to Send Payment <i>(please sign)</i>
Date Signed (MM/DD/YYYY)	Phone Number of Person Authorized to Send Payment

<b>For Internal Use Only</b>	Employer ID Number Issued	Confirmation Number Issued
------------------------------	------------------------------	-------------------------------