Commission EFT Authorization

DentalSelect

Bank information - Please Print

Name on Bank Account:	
Bank Name:	
Bank Address:	
Bank Account Number:	Bank Routing #/ABA #/or Other Bank Code(s):
Agent Contact Person(s):	Agent Contact Phone Number:
Agent Contact Fax Number:	Agent Contact E-Mail:
Agency/Producer Code:	

I certify the information is true and correct and that as an authorized signer for the above named agency permission is granted to Dental Select to deposit funds for monthly commissions due.

Acknowledged and agreed to:

Authorized Signature

Date

Name (Printed)

Title