DentalSelect

Group Binder EFT Authorization Form

Group Name:	Group #:	Payment Amount: $

Initial Binder Payment:

Binder Credit Card Authorization Authorizing Dental Select to withdraw only the one-time initial group binder payment.	☐ Visa ☐ MasterCard	Binder Amount to be Charged to Credit Card: $
Credit Card Number:	Expiration Date: /	CID (3-digit security code)
Card Holder Name: (Last/First/Middle)		
Street Address:		
City:	State:	Zip Code:

I certify that the information above is true and correct and that as an authorized signer for the above named company, authorization is given to Dental Select to electronically process this one-time payment from the designated account.

Authorized Signature: Date Signed (MM/DD/YYYY):

Future Invoice Payment Options:

☐ Option 1 – I wish to be invoiced for future payments (no further action is needed).

☐ Option 2 – I wish to enroll in recurring bank withdrawal for ongoing payments (please complete following section).

Recurring EFT invoice payments may be set up or canceled in Dental Select's web portal at www.dentalselect.com.

Bank Withdrawal Authorization Authorization to honor payments drawn by Dental Select, Salt Lake City, UT.		
Exact Account Name (Please Print):		
Bank Name:	Bank Address:	
Account Number:	Routing #/ ABA #/ or Other Bank Code(s):	
Company Contact Person(s):		
Company Contact Phone #:	Company Contact Fax #:	Company Contact Email:

I certify that the information above is true and correct and that as an authorized signer for the above named company, authorization is given to Dental Select to electronically process payment from the designated account.

Authorized Signature: Date Signed (MM/DD/YYYY):

Name (Printed):	Title: