DentalSelect

Group Electronic Funds Transfer Authorization

Group Information - Please complete the entire form. Please print clearly.

Group Name	Group #

Bank Withdrawal Authorization: Authorization to honor payments drawn by Dental Select, Salt Lake City, UT

☐ One-time Payment Bank Withdrawal Authorization	☐ Recurring Payment Bank Withdrawal Authorization*

Exact Account Name:	
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. The charge will appear on the monthly statement as Dental Select. This authority is to remain in effect until cancelled by written notification to Dental Select.

Acknowledged and Agreed to:

Authorized Signature	Date Signed (MM/DD/YYYY)
Name (Printed):	Title:

Please fax completed form to 801-290-5099

(For your protection, EFT authorization forms are not accepted by email)

* Recurring payments will be processed within two work days of date of invoice issuance, which is on or around the 25th of each month.