Northeast Delta Dental
Provider Services Department
PO Box 2002
Concord, NH 03302-2002

For Vermont
Phone: 1-603-223-1100
Fax: 1-603-223-1033
Email: ProviderServices@nedelta.com
Web: www.nedelta.com

Northeast Delta Dental Claim Payment Direct Deposit Authorization Form

Please complete this agreement and submit it with a voided check or a bank letter to the address or fax number above.

SECTION A: BUSINESS INFORMATION

Authorized Account Holder's Name: _____

Business Name: _____

Business Address: _____

City: _____ State: _____ ZIP: _____

Tax Identification Number (TIN) Used for IRS Reporting: _____

Phone Number: _____ Fax Number: _____

EFT Notification Email Address: _____

SECTION B: BANK/FINANCIAL INSTITUTION INFORMATION

Name of Financial Institution: _____

Bank/Financial Institution Address: _____

City: _____ State: _____ ZIP: _____

Nine-Digit Routing Number: _____ Checking Account Number: _____

Effective Date: _____ Please allow ten (10) business days from receipt date to add, change, or discontinue electronic fund transfers.

National Delta Dental Direct Deposit: NEED VOIDED CHECK or BANK LETTER

☐ Yes, I select **National** Delta Dental Direct Deposit Initial here: _____

By selecting National Delta Dental Direct Deposit, benefit payments from ALL Delta Dental member companies will be electronically deposited into your bank account on file with Northeast Delta Dental. Information on this form and payments made using National Delta Dental Direct Deposit apply to all Delta Dental Participating Providers associated with the Provider Business Information listed above and affiliated with noted TIN. Any information provided to Northeast Delta Dental may be transferred, shared or otherwise provided by Northeast Delta Dental to or with any entity that is an affiliate of Northeast Delta Dental, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association, for use in connection with funds to be deposited to your account.

In consideration for the provision of direct deposit services, by signing below you hereby acknowledge and agree that (i) as of the effective date above, you will elect to receive electronic remittance advices only; (ii) any election to discontinue enrollment in this direct deposit program will take up to ten (10) business days to process, and may not be effective or halt any deposits that were initiated while your enrollment in this direct deposit program was in effect; and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates (if applicable), or Delta Dental Plans Association (if applicable), will be responsible for any damages, or for any fee, charge, or other expense assessed against the designated bank account, in connection with this direct deposit program.

Further, by signing below, you represent and warrant that (i) all of the information you supplied is true and accurate, and (ii) the signatory to this Northeast Delta Dental Direct Deposit Authorization Form ("Form") has all necessary power and authority to execute this Form.

I authorize Northeast Delta Dental and its affiliates to make debit entries against this account in the event that a credit entry is made in error.

Signature of Authorized Person: _____ Title: _____

Printed Name of Authorized Person: _____ Date: _____