



GROUP ACCOUNT WITHDRAWAL AUTHORIZATION FORM

As an officer having authority to withdraw corporate funds on behalf of:
_____ (name of group), I hereby authorize
Delta Dental of Iowa to initiate debit entries to the account indicated below, and the
financial institution named below, to debit the same to such account.

This authorization is for the purpose of paying Delta Dental for claims and administrative
fees, and I understand that the amounts are subject to change based on claim volumes and
eligibility changes.

Weekly withdrawals will be made every Friday.

Bank Information:			
Name of Financial Institution		Branch (if applicable)	
Address of Financial Institution	City	State	Zip Code
Bank Routing Number		Account Number	

This authority is to remain in full force and effect until Delta Dental of Iowa has received
written notification, from an officer of this group, of its termination, in such time and
manner as to afford Delta Dental and the above named financial institution a reasonable
opportunity to act on it.

Group Name (Please Print)

Delta Dental Group Number

Signature and Title of Officer authorized to withdraw funds from bank

Date Signed

Please return to: Delta Dental of Iowa
 Attn: Kathi Erickson
 2401 SE Tones Drive, Suite 13
 Ankeny, IA 50021
 515/261-5515
 Fax #515/261-5609