



## DELTA DENTAL OF IOWA ASC GROUP ACCOUNT WITHDRAWAL AUTHORIZATION

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 groups - Weekly withdrawals will be made every Friday.  
Monthly groups - Withdrawals will be made the Friday following invoice generation.

### Bank Information:

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Name of Financial Institution _____	Branch (If Applicable) _____
Account Type: <input type="checkbox"/> Checking - please attach a voided check	
<input type="checkbox"/> Savings - please attach a pre-printed deposit slip, or indicate:	
Bank Routing Number _____	Account Number _____

This authority for payments is to remain in full force and effect until Delta Dental has received written notification, from an officer of this group, of its withdrawal. You must provide Delta Dental 20 days notice prior to the requested termination date. Termination dates are always the last day of the month.

I certify to the best of my knowledge that the banking information given above is not that of a foreign banking institution (located outside of the United States).\*

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Group Name (please print)	Delta Dental Group ID Number
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Signature & Title of Officer Authorized to Withdraw Funds	Date Signed

\*If your banking institution is a foreign bank, please contact Delta Dental of Iowa for further instructions.

**Please complete and return this form to:**  
Delta Dental of Iowa Attn: Kathi Bieghler  
9000 Northpark Drive, Johnston, Iowa 50131-9010.

Phone: 515-261-5515 Fax: 888-264-0192 Email: [kbieghler@deltadentalia.com](mailto:kbieghler@deltadentalia.com)