



ELECTRONIC TRANSFER AUTHORIZATION

Delta Dental of Kentucky, Inc.
10100 Linn Station Road
Louisville KY 40223

ATTACH VOIDED CHECK HERE

(Please provide a copy of voided check showing ABA transit and account number in space above.)

I hereby authorize Delta Dental of Kentucky, Inc., (hereafter referred to as Company), to deposit any amounts owed me by initiating credit entries to my account at the financial institution (hereinafter referred to as Bank) as indicated above. Further, I authorize Bank to accept and to credit any credit entries indicated by Company to my account. In the event that Company deposits funds erroneously into my account, I authorize company to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such time and in such manner as to afford company and Bank a reasonable opportunity to act on it.

Indicate action desired by circling an option:

Begin Deposit Change Information Cancel

Bank: _____

City: _____ State: _____

Printed Name & Title: _____

Signature: _____ Date: _____

(Please retain a copy for your files.)