Superior Dental Care®
A Medical Mutual® Company

SUPERIOR DENTAL CARE

LEADING THE WAY IN DENTAL BENEFITS

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT

Company Name:_____ **Group Number:**_____

*We hereby authorize **SUPERIOR DENTAL CARE** to initiate debit entries to our account indicated below at the financial institution named below.*

Name on Account:_____

Account Number:_____

Type of account: ☐ CHECKING ☐ SAVINGS

Financial Institution Name:_____

Address:_____

Routing and Transit Number:_____

Please attach a copy of a voided check to ensure proper processing.

*This authorization will remain in full force and effect until **SUPERIOR DENTAL CARE** has received written notification of **ANY** and **ALL** changes **30 DAYS PRIOR** to change date and in such a manner as to afford **SUPERIOR DENTAL CARE** and **BANK** to act upon it.*

NAME OF AUTHORIZED PERSON:_____

SIGNATURE:_____ **DATE:**_____

Please return to:
Superior Dental Care
Attn: Finance Department
6683 Centerville Business Parkway
Centerville, OH 45459

4.6.20