



**SUPERIOR DENTAL CARE
AUTOPAY PROGRAM**

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 (circle one): 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