




Fully Insured Groups

Automated Clearinghouse Authorization Agreement

Company Name _____ authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the Total Amount Due according to our Invoice / Statement. Premium will be taken on the first business day of each month. Group Number _____

ACH Effective Date _____
Bank Name _____
Bank Address _____
Bank Account Number _____
Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank Account Name _____
Bank Routing Number _____ (between these symbols  on the bottom left of your check)
PLEASE INCLUDE A VOIDED CHECK

Authorized individual of the Account _____ Print
Signature _____ Today's Date _____
Title _____ Telephone Number _____
E:Mail address _____

Questions? Please call our Billing and A/R Department at: 1-866-201-1818 (Option 4)

Please complete this form and fax to us at 1-877-803-2433.

or,

Please complete this form and mail to:

Securian Dental Plans
ATTN: Billing and Accounts Receivable
P.O. Box 9304
Minneapolis, MN 55440-9304