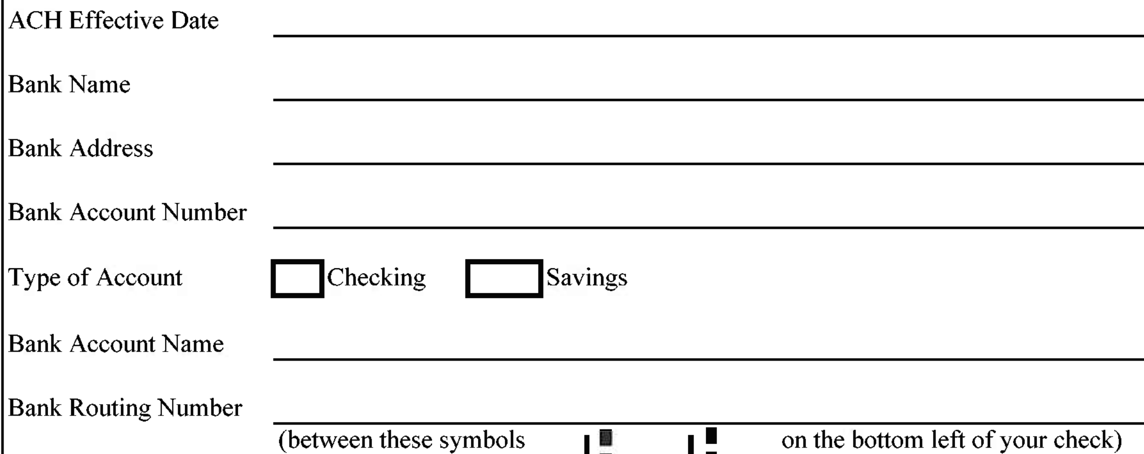
Fully-Insured Groups

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 ☐ Checking ☐ 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 1-877-201-7345.

or,

Please complete this form and mail to:

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