DENTCARE

DELIVERY SYSTEMS, INC.

GROUP INFORMATION

GROUP NAME _____

GROUP ADDRESS _____

_____

_____ _____ _____-_____
City State ZIP Code

CONTACT PERSON _____TELEPHONE # (____) _____-_____

PAYMENT OPTIONS – CHOOSE ONE

☐ **OPTION 1 DIRECT DEBIT**

ROUTING NUMBER |___|___|___|___|___|___|___|___|___|

FINANCIAL INSTITUTION_____

NAME ON ACCOUNT _____

ACCOUNT NUMBER |___|___|___|___|___|___|___|___|___|___| ☐ Checking ☐ Savings
(Check one)

Note: Because of processing time (30 days) 1st payment must be made by check

☐ **OPTION 2 CREDIT CARD**

( ) VISA or ( ) MASTERCARD

NAME ON CARD_____

CARD NUMBER_____ EXPIRATION DATE_____ _____

I authorize Dentcare Delivery Systems, Inc. to either debit the above-referenced account ***or*** charge the above referenced credit card for my premium due. I understand that payment will be made by the 1st business day of each billing cycle.

☐ Monthly ☐ Semi-Annual

☐ Quarterly ☐ Annual IN THE AMOUNT OF $_____._____

AUTHORIZED SIGNATURE_____

PLEASE PRINT NAME_____

TITLE_____ DATE_____