DENTCARE DELIVERY SYSTEMS, INC.

# DENTCARE
# PAYMENT FORM

## Group Information

**Group Name:** _____

**Group Address:** _____

_____

_____ _____ _____
City State Zip Code

**Contact Person:** _____ **Telephone:** _____

## Payment Options

☐ **Direct Debit**

**Routing Number** |___|___|___|___|___|___|___|___|___|___|

**Financial Institution:** _____

**Name on Account:** _____

**Checking Account Number** |___|___|___|___|___|___|___|___|___|___|___|

☐ **Credit Card**

**Please Select:** ☐ **Visa** ☐ **Mastercard**

**Name on Card:** _____

**Card Number:** _____ **Exp. 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** ☐ **Quarterly** IN THE AMOUNT OF $_____

**Authorized Signature** _____

**Please Print Name** _____

**Title** _____ **Date**_____