The Dental Care PLUS GROUP
The plus is service.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

(Required for small groups with 2-9 eligible employees)

Dental Care Plus, Inc. sells goods and/or services to _____(*Company)*. Dental Care Plus, Inc. desires the flexibility to invoice and withdrawal monies for such goods and/or services by electronic funds transfer ("EFT") through the automated clearing house system and _____(*Company*) agrees to grant such flexibility.

Therefore, _____ *(Company)* thereby (1) authorizes Dental Care Plus, Inc. to withdrawal monies for goods and/or services by EFT, (2) certifies that it has selected the following depository institution and (3) directs that all such electronic funds transfers be made as provided below:

Depository Institution: _____

Address: _____

Bank Routing No.: _____

Account Name: _____

Account Number: _____

Account Type: _____Checking

_____Savings

Company EFT Contact: _____

Phone: _____

Fax: _____

_____ *(Company)* will give thirty (30) days advance notice in writing to Dental Care Plus, Inc. of any changes in its depository institution or other payment instructions.

_____
(Signature of Authorized Representative)

_____
(Print Name of Authorized Representative)

_____
(Title)

_____
(Date)

***PLEASE NOTE: THIS FORM AUTHORIZES THE DENTAL CARE PLUS GROUP TO DEDUCT THE MONTHLY PREMIUM FROM THIS ACCOUNT.**