Electronic Funds Transfer (EFT) Authorization

The Dental Care PLUS GROUP
The plus is service.

Dental Care Plus, Inc. has appointed _____ (Agent) to sell its dental and vision insurance products. Dental Care Plus, Inc. desires the flexibility to pay monies for such brokerage services by electronic funds transfer (EFT) through the automated clearing house system and _____ (Agent) agrees to grant such flexibility.

Therefore, _____ (Agent) thereby (1) authorizes Dental Care Plus, Inc. to pay monies for 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:

Agent Information

Agent Name: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Financial Institution Information

Depository Institution: _____

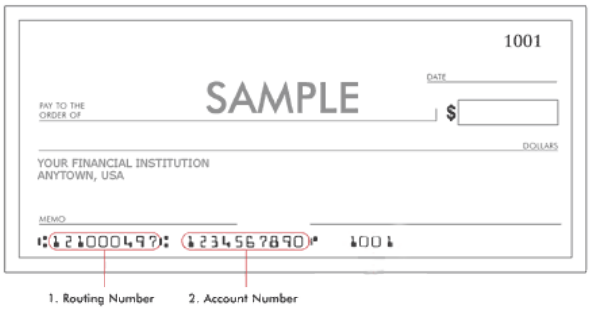
Address: _____

Bank Routing Number: _____

Account Name: _____

Account Number: _____

Account Type: ☐ Checking
☐ Savings



_____ (Agent) 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 _____ Date _____

Print Name of Authorized Representative _____ Title _____

Return completed form to: The Dental Care Plus Group, Attn: Nathan Dietz, 100 Crowne Point Place, Cincinnati, Ohio 45241
OR Fax: (513) 618-3530 **OR** Email: ndietz@dentalcareplus.com

Please note:

- This form only authorizes Dental Care Plus, Inc. to deposit funds into this account.
- Dental Care Plus, Inc. will pay commissions for dental and vision to the same account/depository institution unless otherwise specified.

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