



Auto Deposit Program Authorization Agreement For Direct Deposit

Participating Dentist Name: _____

Tax ID Number: _____

Office Location: _____

We hereby authorize SUPERIOR DENTAL CARE, INC. to initiate credit entries to our account indicated below at the financial institution named below.

Name on the Account: _____

Account Number: _____

Type of account (circle one): CHECKING SAVINGS

Financial Institution Name: _____

Address: _____

Routing and Transit Number: _____

Please attach a copy of a voided check to ensure proper processing.

This authorization will remain in full force and effect until SUPERIOR DENTAL CARE, INC. has received written notification from the Participating Dentist of intent to terminate this service in such time and in such manner as to afford SUPERIOR DENTAL CARE, INC. and BANK to act upon it.

Name of Authorized Person: _____

Signature: _____ Date: _____ Fax Number: _____

Email Address: _____

Please return to: Superior Dental Care, Inc.
Attn: Deb Williams
6683 Centerville Business Parkway
Centerville, OH 45459
www.superiordental.com