SUPERIOR DENTAL CARE
AUTOPAY PROGRAM

LEADING THE WAY IN DENTAL BENEFITS

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT

Company Name:____ **Group Number:**______________________

*We hereby authorize **SUPERIOR DENTAL CARE** to initiate debit entries to our account indicated below at the financial institution named below.*

Name on 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** has received written notification from the **COMPANY** of intent to terminate this service in such time (30 days prior to the termination date) and in such manner as to afford **SUPERIOR DENTAL CARE** and **BANK** to act upon it.*

NAME OF AUTHORIZED PERSON:____

SIGNATURE:____ **DATE:**______________________

Please return to: **Superior Dental Care**
Attn: Finance Department
6683 Centerville Business Parkway
Centerville, OH 45459

October 2011