


**Dental Fully Insured Groups  
Automated Clearinghouse Authorization Agreement**

<b>Company Name</b>	_____
	authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the <b>Total Amount Due</b> according to our Invoice / Statement. Premium will be taken on the first business day of each month.
<b>Group Number</b>	_____

<b>ACH Effective Date</b>	_____
<b>Bank Name</b>	_____
<b>Bank Address</b>	_____
<b>Bank Account Number</b>	_____
<b>Type of Account</b>	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
<b>Bank Account Name</b>	_____
<b>Bank Routing Number</b>	_____
	(between these symbols  on the bottom left of your check) <b>PLEASE INCLUDE A VOIDED CHECK</b>

<b>Authorized Individual of the Account</b>	_____	
	Print	
	_____	_____
	Signature	Today's Date
	_____	_____
	Title	Telephone Number
	_____	
	E-Mail address	

**Questions? Please call our Billing and A/R Department at: 1-877-606-3409**  
**Please complete this form and fax to us at: 1-877-803-2433**  
**or,**  
**Please complete this form and mail to:**

**Anthem**  
**ATTN: Dental Billing and A/R**  
**PO Box 1171**  
**Minneapolis, MN 55440-1171**

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