Direct Deposit Agreement

AGENT/AGENCY INFORMATION
Agency/Agent Name:
Business Tax Identification Number:

BANKING/FINANCIAL INSTITUTION INFORMATION			
☐ Checking ☐ Savings	Account Number:	Routing Number:	
Institution's Name:		Branch:	
Address:			
City:	State:	ZIP:	
Telephone:	Fax:		
Attach a pre encoded or voided check			

☐ AUTHORIZATION

I hereby recognize Delta Dental of Arkansas, Inc. through Arvest Bank of Lowell, AR (the "Bank") to initiate direct deposit commission credit entries to my checking/savings account indicated above and the Financial Institution above to post the same to such account.

This authorization is to remain in force until the Bank receives notice of cancellation from me (see below). The notice of cancellation must be received at least 30 days prior to cancellation and in such a manner as to afford the Bank reasonable opportunity to act on it and in no event shall it be effective with respect to entries processed by the Bank prior to the receipt of the notice of cancellation.

I further authorize the Bank to initiate such debit entries to said account as may be necessary to correct any erroneous credit entries previously initiated there to and I authorize the Financial Institution to accept and to credit or debit the amount of such entries to my account.

All entries initiated hereunder are to be governed by the rules of Mid-America Payment Exchange as now or hereafter in effect.

☐ CANCELLATION STATEMENT

I hereby cancel the authorization for to originate direct deposit entries to my checking/savings account indicated above, effective on the following date _____.

_____ Signature

_____ Date Signed

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