Cypress Dental Administrators
7510 Shoreline Drive, Suite A-1
Stockton, CA 95219
800-350-3989
209-478-5614-fax

Cypress Dental Electronic Funds Transfer Authorization

Group Name:	
Group Number:	
Group Contact Person:	Phone Number:
Group Contact Email Address:	

Bank Name:	
Account Holder Name:	Checking ☐ Savings ☐
Routing number:	Account number:

You will continue to receive a monthly invoice which will indicate the amount that will be automatically deducted from the account the following month.

I hereby authorize Cypress Dental Administrators to initiate premium deductions and/or administrative fee deductions via Electronic Funds Transfer (ACH) debit transactions from the designated account listed above for this company's active group. This authorization will remain in effect until Cypress Dental Administrators has received written notification of termination. Notice must be received in time and in such a manner to afford Cypress Dental Administrators reasonable opportunity to act on it. The debit will occur on or after the 1st business day of the month for that month's coverage and will be on a pay-as-billed basis. A return fee of $15 will be applied to any returned items.

Authorized signature(s):_____ Date:_____

Print name:_____ Title:_____

Please fax or mail the completed Authorization form with a copy of voided check to:
Cypress Dental Administrators
7510 Shoreline Drive, Ste A-1
Stockton, CA 95219
Fax: 209-478-5614