DELTA DENTAL®

Direct Deposit Enrollment Form

(Participating Dentists Only)

PLEASE SUBMIT A SEPARATE FORM FOR EACH TAX ID IF ENROLLING MULTIPLE BUSINESSES
Business Tax Identification Number:

Direct Deposit Authorization type: (select one)	**Direct Deposit Authorization applies to these offices:** (select one)	**Direct Deposit Authorization applies to:** (select one)
☐ **New Authorization** (complete section A, B, C, D, and G) ☐ **Changes to an existing authorization** (complete sections A, B, C, E, and G) ☐ **Cancellation** (complete sections A and F)	☐ All service office locations associated with this Tax Id ☐ Service office locations listed on this form only	☐ **Delta Dental of Arkansas (including Smiles)** ☐ **Delta Dental of Arkansas and Affiliates (AR, MI, IN, OH, NC, KY, NM, TN, NE)** ☐ **All Delta Dental Plans**

In consideration for the provision of direct deposit services, by signing below, and notwithstanding any language to the contrary herein, you hereby acknowledge and agree that (i) any information you have provided, including but not limited to, the information you supplied under the heading "Banking Information" below, may be transferred, shared or otherwise provided by us to or with any entity that is an affiliate of Delta Dental, as defined above, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association, for use in connection with funds to be deposited to your account, (ii) any election to discontinue enrollment in this direct deposit program will take 10-15 business days to process, and may not be effective to halt any deposits that were initiated while your enrollment in this direct deposit program was in effect, and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates, or Delta Dental Plans Association, will be responsible for any damages, or for any fee, charge or other expense assessed against the Bank Account identified above, in connection with this direct deposit program.

Further, by signing below, you represent and warrant that (i) all of the information you supplied is true and accurate, (ii) the information provided under the heading "Banking Information," above, identifies a bank account held by the Business you identified above, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form.

Questions? Contact a Professional Relations Representative at 501-992-1710

Delta Dental of Arkansas Professional Relations Department, P.O. Box 15965, Little Rock, AR 72231
profrel@DDPAR.com • (501) 992-1710 • FAX: (501) 992-1867 attn: PR Department

A. DENTIST INFORMATION		
Dentist Name:		
Provider's License Number:	Issuing State:	
Name of Office Contact:		
Service Office Location (physical address):		
City:	State:	ZIP:
Telephone:	Fax:	
Email:		

B. BANKING/FINANCIAL INSTITUTION INFORMATION		
Name of Account Holder (business name):		
Institution's Name:	Branch:	
Address:		
City:	State:	ZIP:
Telephone:	Fax:	

C. AUTOMATIC DEPOSIT	
☐ I submit Claims electronically through a clearinghouse or the internet.	☐ I **DO NOT** submit Claims electronically.

D. AUTHORIZATION

I authorize and request Delta Dental Plan of Arkansas, Inc. (hereinafter called DDAR) to send the net claims check directly to my bank or other financial institution as specified in Section B of this form. I also agree to the Terms and Conditions set out below. I understand I may terminate this authorization at any time by completing another "Direct Deposit Enrollment Form" or in any event by sending a thirty (30) day written notice to DDAR to terminate (with new request/instructions for future payment).

_____ _____

Dentist Signature Date Signed

E. CHANGE AUTHORIZATION STATEMENT

I authorize and request Delta Dental to make the changes indicated on this form. I will give Delta Dental thirty (30) days from date of its receipt of this document to accomplish these changes.

_____ _____

Dentist Signature Date Signed

F. CANCELLATION STATEMENT

I authorize and request Delta Dental to terminate authorized direct deposits to my account. I will give Delta Dental thirty (30) days' notice from receipt date of this document, to accomplish these changes. Unless otherwise noted, upon such cancellation (future) payments will be made to the participating dentist by paper check.

_____ _____

Dentist Signature Date Signed

G. DOCUMENTS REQUIRED FOR ACCOUNT VERIFICATION

Please attach one of the following documents

- A copy of a voided check marked "SAMPLE" **OR**
- Deposit Account Verification Letter from your financial institution (Must be printed on the bank's official letterhead, signed by a bank administrator, and contain your business name, routing number and account number).

Please return completed form to:

Delta Dental Plan of Arkansas, Inc.
PO Box 15965
Little Rock, AR 72231
Fax: 501-992-1867
Email: provider@ddpar.com

TERMS AND CONDITIONS:

You agree to comply with all applicable laws, rules and regulations related to electronic funds transfers. You also agree that you are solely responsible for maintaining the confidentiality of the user names, passwords, and security question answers used by you and any users within your organization for this website. If you permit other persons to use your user name, password, or security question answers, you are responsible for any transactions or changes they authorize from, or that relate to, your account(s) or the EFT services. Delta Dental is not liable for any harm associated with theft or unauthorized use of user names, passwords, or security question answers used by you or your organization. You shall immediately notify Delta Dental of any unauthorized use of your user name, password, security question answers, or account(s). You shall notify Delta Dental immediately in writing if any designated contact is no longer authorized to transact business or make changes on behalf of you or your organization. You agree that: (i) Delta Dental may process all instructions related to EFTs that are or appear to be submitted by your designated contacts and that such instructions are effective even if not authorized by you; (ii) you will maintain appropriate accounting and auditing procedures to protect your Account(s) from misuse; and (iii) you will promptly review all electronic statements, notices and transaction information made available to you and you shall report all unauthorized transactions and errors to Delta Dental immediately.

You agree to indemnify, defend and hold Delta Dental harmless from and against any and all losses, liabilities, costs, damages and expenses, including litigation expenses and reasonable attorneys' fees and allocated costs for in-house legal services arising from or incurred as the result of your breach of this Agreement, any inaccurate or incomplete data you provide or fail to provide to us, your failure to timely update information, and/or the negligence or willful misconduct of you, your directors, officers, employees, designees, agents and affiliates. In no event shall Delta Dental, its parent, affiliates, subsidiaries, directors, officers, employees, agents or representatives be liable for special incidental or consequential damages or claims by you or any third party relative to the EFT services provided hereunder. Delta Dental shall not be liable if circumstances beyond its control prevent a payment, despite taking reasonable precautions. Such circumstances include but are not limited to, delays or losses of payments caused by telecommunications outages, actions of third parties and equipment failures.