



7510 Shoreline Drive  
 Stockton, CA 95219  
 (800) 350-3989  
 billing@cypressadmin.com

## AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize Cypress Dental to electronically debit my account (and if necessary, to electronically credit my account to correct erroneous debits) at the financial institution named below. I agree that the ACH transactions I authorize comply with all applicable laws.

Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

**Authorization Frequency:** (please check one)

One Time Only for \$ \_\_\_\_\_  Recurring Monthly Premium Payment

Bank Name: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Checking Account  Savings Account

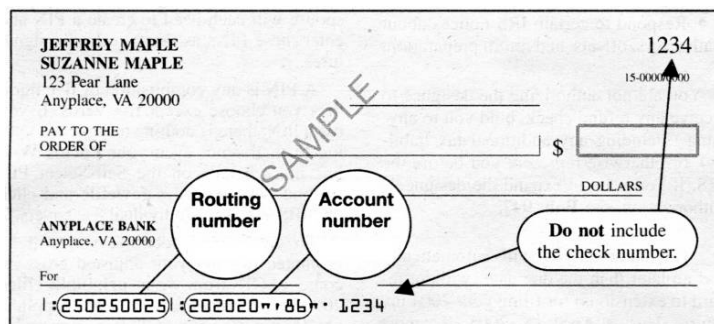
I understand that this authorization will remain in full force and effect until I notify Cypress Dental in writing at 7510 Shoreline Drive, Stockton CA 95219, Attn: Billing Administration, or by calling 800-350-3989 at least 30 days prior to the proposed effective date of the termination of authorization.

**PLEASE NOTE: You will continue to receive a monthly invoice which will indicate the amount that will be automatically deducted from the account the following month. The debit will occur between the 1<sup>st</sup> and 5<sup>th</sup> of every month for the current coverage month. A return fee of \$25 will be applied to any returned items.**

Authorized Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

***Please attached a VOIDED CHECK to this authorization if a checking account will be debited.***



Note. The routing and account numbers may be in different places on your check.