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

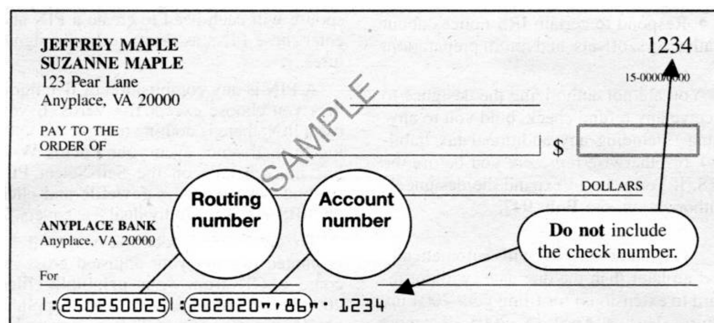
I understand that this authorization will remain in full force and effect until I notify Cypress Dental in writing at 7510 Shoreline Drive, Stockton CA 95219, Attn: Billing Administration, or by calling 800-350-3989 at least 30 days prior to the proposed effective date of the termination of authorization.

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 1st and 5th of every month for the current coverage month. A return fee of $15 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.