Electronic Funds Transfer (EFT) Application

Name of Company ______________________________

Group Number ______________________________

I hereby authorize the Ohio Dental Association Wellness Trust to initiate debit entries to the checking or saving account indicated below at the depository financial institution named below and to debit the same account for the dollar amount of group health care benefits invoice due the Ohio Dental Association Wellness Trust on the invoice due date, which will usually occur on the first banking day of each month.

Bank Name: ______________________________

City State and Zip: ______________________________

Transit / ABA No: ______________________________

Bank Account Number: ______________________________

Account Type: Checking Savings (Check One)

This authority will remain in full force and effective until the Ohio Dental Association Wellness Trust has received written notification **30** days prior to its termination, which gives the Ohio Dental Association Wellness Trust a reasonable opportunity to act on it. I understand that if for any reason our electronic funds transfer (EFT) is returned for insufficient funds, the Ohio Dental Association Wellness Trust will permanently remove the group from the EFT program and I will be responsible for making the payment monthly. I acknowledge that I have retained a copy of this agreement for my records.

Group Official Signature: ______________________________

Title: ______________________________

Date: ______________________________