



Send Completed Form to:
 Dentcare Delivery Systems, Inc.
 Attn: Accounting Department
 333 Earle Ovington Blvd., Suite 300
 Uniondale, NY 11553-3608
 E accounting@healthplex.com • F 516-745-0079

GROUP PAYMENT FORM

GROUP INFORMATION			
Company Name		Group Number	
Address	City	State	Zip Code
Contact Person	Phone	Email Address	
PAYMENT OPTIONS			
<input type="checkbox"/> Direct Debit *Allow 30 days for initial payment processing. First payment must be made by check.			
Routing Number	Account Number		
Financial Institution			
Name on Account			
<input type="checkbox"/> Credit Card	Please Select: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover		
Name on Card (Last, First, M.I.)	Company Name on Card (if applicable)		
Card Number		Expiration Date	
<i>An additional \$5.00 processing fee will be added to any credit card charge.</i>			
AUTHORIZATION			
<i>Authorization Agreement for Direct Pay: I hereby authorize Dentcare Delivery Systems, Inc. to initiate direct debits from the above-referenced bank account and give Dentcare Delivery Systems, Inc. authorization from the group to instruct the financial institution to debit such account for premium payments due. I understand that the monthly direct debit of invoiced amounts will be processed approximately on the 5th business day of each month. I also understand that three (3) business days (in writing) are required to deactivate Direct Pay. Such request can be provided via mail, fax or email.</i>			
Authorized Signature		Print Name	
Title		Date	