DirectPay Authorization

☐ New – add to **DirectPay** System ☐ Information Change

Agent Name:____

I/We authorize **Direct Dental Alliance** hereinafter called DDA, to initiate Electronic Funds Transfer (EFT) to my **Checking Account** indicated below and the bank named below to deposit the same to such account.

Bank Name____

Address ____

City__________________________________State_________Zip Code ______________

Transit / ABA Number________________________Account Number _________________________

This authority is to remain in full force and effect until DDP has received written notification from me/us of its termination, in such time and manner as to afford DDP a reasonable opportunity to act on it.

Printed Name on Account____Date ______________

Authorized Signature ____

Please attach a copy of a **VOIDED CHECK** from the account to which **DirectPay** is to be deposited and either;

1. Scan and email this document and your voided check to: brokersupport@directdentalalliance.com, or
2. Fax this document and your voided check to: (720) 634-2652