Direct Deposit Enrollment Form

This Form is for Delta Dental of Kansas Participating Dentists

Note: The information disclosed below is confidential and will not be used other than for payment of dental services.

DIRECT DEPOSIT AUTHORIZATION APPLIES TO: (Select One)

- ☐ **Delta Dental of Kansas ONLY**
- ☐ **All Delta Dental Plans -** Enroll me in National Direct Deposit for all Delta Dental Member Companies

If "All Delta Dental Plans" is selected above, in consideration for the provision of direct deposit services, by signing this form, and notwithstanding any language to the contrary herein, you hereby acknowledge and agree that (i) any information you have provided, including but not limited to, the information you supplied under the heading "Banking Information" on this form, may be transferred, shared or otherwise provided by Delta Dental of Kansas (DDKS) to or with any entity that is an affiliate of Delta Dental, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association, for use in connection with funds to be deposited to your account, (ii) any election to discontinue enrollment in this direct deposit program will take 10-15 business days to process, and may not be effective to halt any deposits that were initiated while your enrollment in this direct deposit program was in effect, and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates, or Delta Dental Plans Association, will be responsible for any damages, or for any fee, charge or other expense assessed against the Bank Account identified below, in connection with this direct deposit program. Such damages and expenses shall include, but are not limited to, litigation expenses and reasonable attorneys' fees and allocated costs for in-house legal services arising from or incurred as a result of your breach of this Agreement, as well as special incidental or consequential damages or claims by you or any third party relative to the direct deposit services provided hereunder.

By signing this form, you represent and warrant that (i) all of the information you supplied is true and accurate, (ii) the information provided under the heading "Banking Information," identifies a bank account held by the Business you identified on this form, and (iii) the signatory to this Direct Deposit Enrollment Form ("form") has all necessary power and authority to execute this form.

SELECT ONE OF THE FOLLOWING

- ☐ **New Authorization**
- ☐ **Change Banking Information**
- ☐ **Change an Existing Password or Email Address**
- ☐ **Cancellation**
  - ☐ Cancel Enrollment in National Direct Deposit but keep me enrolled in Kansas Direct Deposit
  - ☐ Cancel all Direct Deposit enrollments (includes Kansas and National)

LOCATION(S) INFORMATION: (Please copy this page as needed for additional locations using the same TIN)

TIN: _____

First Location - Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

Dentist Office Contact: _____ Contact's Email: _____

Second Location - Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

Dentist Office Contact: _____ Contact's Email: _____

Third Location - Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

Dentist Office Contact: _____ Contact's Email: _____

Return to Delta Dental of Kansas:
Attn: CONTROLLER mail: P.O. Box 789769 Wichita, KS 67278-9769 | fax: 316.462.3331

316.264.1099 | DeltaDentalKS.com

Revision Date 6/2019

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ELECTRONIC REMITTANCE ADVICE (ERA) RETRIEVAL

Both Local and National ERAs will be available online through your Dentist account at DeltaDentalKS.com. For local ERAs, you will receive an email notification sent to the email provided below when an ERA is available.

To access local ERAs, you must create additional Login Credentials below *(save these login credentials to access your local ERAs once you are setup in the system. Please note, this information should be kept confidential)*:

Username: Your TIN *(no spaces or dashes)*

Password: _____

(password requires a minimum of eight (8) and maximum of fifteen (15) and at least one uppercase letter, one lowercase letter and one number)

Email address for ERA notification: _____

(if multiple TINs exist, a separate enrollment form and a different email address for ERA notification must be used for each TIN)

BANKING/FINANCIAL INSTITUTION INFORMATION

Name of Account Holder: _____

Institution Name: _____ Branch (if applicable): _____

Bank Routing Number: _____ Account Number: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Type of Account: ☐ Checking ☐ Savings ☐ Other: _____
(please specify account type)

Please attach one of the following documents for account verification purposes*:

- A copy of a check marked "VOID"
  or
- Deposit Account Verification Letter from your financial institution (Letter must be printed on bank's official letterhead, signed by a bank administrator, and contain your business name, routing number and account number.)

*Validation is not required if there are no changes to your banking/financial institution information.

DENTIST INFORMATION: (For Participating Kansas Dentists Only)

I authorize and request Delta Dental of Kansas, (hereinafter called DDKS) to send the net claims check directly to my bank or other financial institution as specified on this form. I also agree to the Terms and Conditions set out on this form. I understand I may terminate this authorization at any time by completing another "Direct Deposit Enrollment Form" or in any event by sending a thirty (30) day written notice to DDKS to terminate (with new request/instructions for future payment).

Please note: Each licensed dentist who desires to participate must sign the Direct Deposit Enrollment Form. If more space is needed, please make copies of this page and provide additional names, license numbers and signatures.

Dentist Name: _____ Dentist License Number: _____

Dentist Signature: _____ Date: _____

Dentist Name: _____ Dentist License Number: _____

Dentist Signature: _____ Date: _____

Dentist Name: _____ Dentist License Number: _____

Dentist Signature: _____ Date: _____

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