Delta Dental of South Dakota

Direct Deposit Enrollment Form

Participating Dentists Only

Business Tax ID Number: ______________________________

(If enrolling multiple businesses, please submit a separate form for each Tax ID)

Direct Deposit Authorization Type: (select one)

- ☐ New Authorization (complete section A, B, C, D and G)
- ☐ Changes to an existing authorization (complete sections A, B, C, E and G)
- ☐ Cancellation (complete sections A and F)

Direct Deposit Authorization Applies to these Offices: (select one)

- ☐ All service office locations associated with this Tax ID
- ☐ Service office locations listed on this form only

Direct Deposit Authorization Applies To: (select one)

- ☐ Delta Dental of South Dakota ONLY
- ☐ All Delta Dental Member Companies

In consideration for the provision of direct deposit services, by signing below, 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" below, may be transferred, shared or otherwise provided by us to or with other Delta Dental member companies 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 Delta Dental of South Dakota, Delta Dental Member Companies 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 above, in connection with this direct deposit program.

Further, by signing below, 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," above, identifies a bank account held by the business you identified above, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form.

A. DENTIST INFORMATION

(If enrolling multiple providers, please submit a separate form for each provider)

Dentist Name: ______________________________

Provider's License Number: ______________ Issuing State: ______________

Service Office Location *(Physical Address)*: ______________________________

City: ______________ State: ________ Zip Code: ______________

Phone Number: ______________ Fax Number: ______________

Name of Office Contact: ______________________________

Email Address to receive EOB notification: ______________________________

B. BANKING/FINANCIAL INSTITUTION INFORMATION

Name of Account Holder (Business Name):______________________________________
Institution's Name:____
Bank Routing Number:_______________________ Account Number: ______________________
Address:____
City:_________________________ State:_________ Zip Code: ___________________________
Telephone Number:____

C. AUTOMATIC DEPOSIT

☐ I submit claims electronically through a clearinghouse or the internet.
☐ I do not submit claims electronically.

D. AUTHORIZATION

I authorize and request Delta Dental of South Dakota (hereinafter called DDSD) to send the net claims check directly to my bank or other financial institution as specified in Section B of this form. I also agree to the Terms and Conditions set out below. 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 DDSD to terminate (with new request/instructions for future payment).

____
Dentist Signature Date Signed

E. CHANGE AUTHORIZATION STATEMENT

I authorize and request Delta Dental of South Dakota to make the changes indicated on this form. I will give DDSD thirty (30) days from date of its receipt of this document to accomplish these changes.

____
Dentist Signature Date Signed

DELTA DENTAL

F. CANCELLATION STATEMENT

I authorize and request DDSD to terminate authorized direct deposits to my account. I will give DDSD thirty (30) days' notice from receipt date of this document to accomplish these changes. Unless otherwise noted, upon such cancellation (future) payments will be made to the participation dentist by paper check.

Dentist Signature Date Signed

G. ATTACH ONE OF THE FOLLOWING DOCUMENTS FOR ACCOUNT VERIFICATION PURPOSES

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

Please return the completed form to:

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501 Fax: 605-494-2566

TERMS AND CONDITIONS:

You agree to comply with all applicable laws, rules and regulations related to electronic funds transfers. You also agree that you are solely responsible for maintain the confidentiality of the user names, passwords, and security question answers used by you and any users within your organization for this website. If you permit other persons to use your user name, password, or security question answers, you are responsible for any transactions or changes associated with theft or unauthorized use of user names, passwords, or security question answers used by you or your organization. You shall immediately notify Delta Dental of South Dakota of any unauthorized use of your user name, password, security question answers, or account(s). You shall notify DDSD immediately in writing if any designated contact is no longer authorized to transact business or make changes on behalf of you or your organization. You agree that: (i) DDSD may process all instructions related to EFTs that are or appear to be submitted by your designated contacts and that such instructions are effective even if not authorized by you; (ii) you will maintain appropriate accounting and auditing procedures to protect your Account(s) from misuse; and (iii) you will promptly review all electronic statements, notices and transaction information made available to you and you shall report all unauthorized transactions and errors to Delta Dental immediately.

You agree to indemnify, defend and hold DDSD harmless from and against any and all losses, liabilities, costs, damages and expenses, including litigation expenses and reasonable attorneys' fees and allocated costs for in-house legal services arising from or incurred as the result of your breach of this Agreement, any inaccurate or incomplete data you provide or fail to provide to us, your failure to timely update information, and/or the negligence or willful misconduct of you, your directors, officers, employees, designees, agents and affiliates. In no event shall DDSD, its parent, directors, officers, employees, agents or representatives be liable for special incidental or consequential damages or claims by you or any third party relative to the EFT services provided hereunder. DDSD shall not be liable if circumstances beyond its control prevent a payment, despite taking reasonable precautions. Such circumstances include but are not limited to, delays or losses of payments caused by telecommunications outages, actions of third parties and equipment failures.