ELECTRONIC PAYMENT AUTHORIZATION

Broker or Affiliate ID #: _____

Name: _____

Phone: _____

ATTACH VOIDED CHECK

Bank Account Information:

Account Holder: _____

Financial Institution Name: _____

Nine digit ABA Routing #: _____

Account #: _____

I authorize DentalPlans.com to remit my commissions electronically to the account named above. If I choose to discontinue this method of payment, I will notify DentalPlans.com in writing.

_____ _____
Signature Date

_____
Print Name