Electronic Fund Transfer (EFT) Form

(Print Clearly)

Type of Authorization: ☐ Add ☐ Update ☐ Cancel

OFFICE INFORMATION

Payee Name:	**Tax ID:**
Payee Address:	**Email Address:**
	Updated to Email Address:
Office Name:	**Office ID # :**

ACCOUNT INFORMATION

Account Legal Name:	Account Number:
Account Type: ☐ **Checking** ☐ **Savings**	Bank Routing Number:
Name of Financial Institution:	

One of the following must be attached:

MEMO
⑆000000000⑆ ⑆000000000⑈ ⑆025

Routing Number Account Number

☐ Voided Check
☐ Confirmation letter from your bank with required account information

AUTHORIZATION

Please note that all references to "me," "my" or "I" below refer to the dental office contracted with LIBERTY Dental Plan and to which payments shall be directly deposited by LIBERTY Dental Plan under this authorization form.

By signing below, I hereby authorize LIBERTY Dental Plan to deposit any amounts due to me, less any mandatory or authorized withholdings or deductions, into the account indicated on this form. I understand that my payment statements will be available online and that paper statements will no longer be provided to me.

If at any time the amount so deposited exceeds the amount actually due and payable to me, I hereby authorize LIBERTY Dental Plan to either: (i) withhold a sum equal to the overpayment from future amounts due to me; or (ii) recover such overpayment from the above-indicated account. I understand that it is my responsibility to verify that payments have been credited to my account and I agree that LIBERTY Dental Plan assumes no liability for overdrafts for any reason whatsoever. I further understand that in the event my financial institution is not able to deposit any electronic transfer into my account due to any action or inaction by me, LIBERTY Dental Plan cannot issue the funds to me until the funds are returned to LIBERTY Dental Plan by the financial institution.

I certify that the account is drawn in my name and that I have sole control of the account. I certify that the account is drawn in the legal business name of the dental office and that such dental office has sole control of the account. Either way, I certify that all arrangements between my financial institution(s) and me are in accordance with all applicable federal and state laws and regulations.

This authorization will remain in effect until I have submitted a new Electronic Fund Transfer Form to LIBERTY Dental Plan or until either Dental Plan or I have provided the other with written notice to terminate this authorization or direct deposit arrangement. I understand that I can change my account information or financial institution arrangement by completing a new Electronic Fund Transfer Form available from LIBERTY Dental Plan. I agree to immediately notify LIBERTY Dental Plan before I close any account listed above while this authorization is in effect.

By signing below, I certify that 100% of the net deposit will not be sent to a financial institution outside the jurisdiction of the United States.

Authorized Signature:	Date:
Print Name:	Title:

CANCELLATION

I hereby consent to cancel my Electronic Fund Transfer Authorization.

Authorized Signature:	Date:
Print Name:	Title:

LIBERTY DENTAL PLAN USE ONLY

Vendor Name:	Vendor ID:

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Instructions for Completing the Electronic Fund Transfer (EFT) Form

- Please allow 30 days after submission of form to receive your first Electronic Fund Transfer (EFT) deposit.
- Forms that are illegible or not fully or accurately completed will result in delays in processing the EFT deposit arrangement.

General Instructions

Complete all portions of the form according to the type of enrollment and sign where required.

Office Information

Clearly print and complete all parts of this section for any addition, update or cancellation to account.

- **Payee Name:** Must match office name on check
- **Payee Address:** Must match address on check
- **Email Address**: Enter your current email address for verification purposes
- **Updated to Email Address:** Clearly print the email address you wish to update the account to. A voided check or bank letter will not be required for submission if this is the only change to the account information.
- **Office Name:** DBA
- **Office Number:** Completed by LIBERTY Dental Plan representative

Account Information

Attach a voided check or Confirmation Letter from your bank for the account listed. Please note that this EFT Form will not be processed unless the voided check or bank letter is attached.

Authorization

An authorized signature is required for any addition, change or update to an account. The signer's name must be clearly printed under the signature, title provided, and form dated. Omission will result in delays in processing this EFT form.

Cancellation

An authorized signature is required for cancellation of the EFT deposit arrangement. The authorized signer's name must be clearly printed under the signature, title provided, and form dated. Omissions will result in delays in processing of the EFT form.

Form Submission

Please return the completed EFT form along with all required documents in one of the following ways:

Email	Provider@libertydentalplan.com	**Mail**	Attn. Provider Relations LIBERTY Dental Plan P.O. Box 26110 Santa Ana, CA 92799-6110