ARCORA
The Foundation of Delta Dental of Washington

Authorization Agreement for ACH Payments

Name _____

Mailing Address _____

City, State, Zip _____

☐ New Direct Deposit ☐ Checking

Organization Contact Name _____

Organization Email _____

I hereby authorize Arcora Foundation to make payments to my bank account as indicated below:

Account Name: _____

Bank Name: _____

Account Number: _____

Routing Number: _____

Signature: _____ Date: _____