DELTA DENTAL®

Agent/Agency Licensing Information Form

For an appointment with Delta Dental of Massachusetts, please provide the following information:

- Completed Agent/Agency Licensing Information Form.
- A signed agent/agency commission agreement/broker contract.
- If commissions are to be paid electronically, complete the EFT Vendor Direct Payment Authorization Form on next page.
- Completed W-9 from the IRS: https://www.irs.gov/forms-pubs/about-form-w-9
- Copy of your Agent/Agency License.

Mail to:
Delta Dental of Massachusetts
Attention: Broker Commissions
465 Medford St, Ste. 400
Boston, MA 02129

OR

Email to:
DHaglund@deltadentalmass.com

Section I – Agent/Agency information

1. Full name:		
2. Agency name:		
3. Correspondence address:		
4. City/Town:	5. State:	6. Zip code:
7. Contact name:	8. Contact phone:	
9. Contact email address:		

Section II – Commissions information

10. Agent/Agency Tax ID:										
11. Agent/Agency NPN ID:										
12. Agent/Agency Exchange User ID:										
13. Agency Commissions contact name:										
14. Payment method*: ☐ Check ☐ EFT/Direct Deposit *If payment method is EFT, please complete the enclosed EFT Payment Authorization Form and submit with a voided check.										
15. Statement remittance method: ☐ Mail/Postal ☐ Electronic (Excel via email)										
16. Payment remittance address:										
17. City/Town:				18. State:				19. Zip code:		

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Electronic Funds Transfer (EFT)
Vendor Direct Payment Authorization Form

For your convenience and benefit, Delta Dental of Massachusetts offers payees the opportunity to receive future payments electronically, rather than by check. Your payments will be deposited into the checking or savings account you specify below. In addition to having the money deposited electronically, you also will be notified of the deposit by email. The email will provide you with all the information that would normally be on your check stub. To receive payments electronically, you must print, complete this form, attach a voided check, and return both to the address below.

Instructions: Please complete both sections of this Authorization Form and attach a voided check.

Mail to: Delta Dental of Massachusetts, Attention: Accounts Payable, 465 Medford St, Ste. 400, Boston, MA 02129	
Authorization is: ☐ New ☐ Change	**Vendor number:** (To be completed by Accounts Payable)

Section I – Vendor information

1. Vendor name:		
2. Taxpayer ID number or social security number:		Enter numerical values without dashes
3. Vendor street address:		
4. Vendor city/town:	5. Vendor state:	6. Vendor zip code:
7. Contact person name:	8. Contact person phone:	
9. Vendor email address for remittance notification:		
10. Vendor authorization:		

Authorized signature _____ Print name/title _____ Date _____

Section II – Financial institution information

11. Bank name:		
12. Bank street address:		
13. Bank city/town:	Bank state:	Bank zip code:
14. Routing transit number:	15. Account type: ☐ Checking ☐ Savings	
16. Bank account number:	17. Bank account name:	
18. Bank contact name:	19. Bank contact telephone:	

20. FINANCIAL INSTITUTION CERTIFICATION: (required ONLY if directing funds into a savings account OR a voided check is not attached to this form): I certify that the account number and type of account is maintained in the name of the vendor named above. As a representative of the named financial institution, I certify that this financial institution is ACH capable and agrees to receive and deposit payments to the account shown.

Authorized signature _____ Print name/title _____ Date _____