Dental Direct Deposit Form

THE PBAS GROUP

Direct deposit will be used for reimbursement of your Dental Claims. Direct deposit reimbursements ensure that your payments are made directly into your bank account.

Most chartered banks, trust companies, credit unions and treasury branches facilitate direct deposit. You should check with your financial institution to make sure you can receive payment into the account selected below. If necessary, your financial institution can help you complete this form.

After each claim has been processed, an Explanation of Payments (EOP) will be mailed electronically to the email address that you provide. Notifications will provide you with the details of how the claim was processed including deductibles, percentage payable and plan maximums. A copy of the EOP can be submitted to a second insurer if the patient is covered under a second plan.

Instructions:

1. All three (3) sections on this form are mandatory and must be completed in full prior to submitting the form.
2. Please fax, scan, or forward the completed form to Prudent Benefits Administration Services Inc. ("The PBAS Group") to the address listed below.

110–61 International Blvd.
Toronto, ON M9W 6K4

Toll Free (800) 461-4361
Fax: (416) 674-1525

1. Company Information

Name of Dental Office		Name of Dentist	
Provider Number	**Office Number**	**Email Address**	
Mailing Address No. and Street	**City**	**Province**	**Postal Code**

2. Bank Account Information

Transit Number (5 Digits)	Institution Number (3 Digits)	Bank Account Number (7 Digits to 12 Digits)
Email Address for Explanation of Payments (EOP)		

3. Declaration of Consent

I understand that The PBAS Group collects and uses the above personal information to set up direct deposit service with my financial institution to deposit claim reimbursements (when applicable) into my bank account. It is necessary for Prudent Benefits Administration Services Inc. ("The PBAS Group") to disclose some or all of the above personal information to their financial institution for these purposes. I understand why the information is required and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. I, hereby, consent to the collection, use and disclosure of my personal information as described above. This consent may be revoked at any time. I declare that the information in this application is complete, accurate and true.

Date	Signature of Dentist	Telephone Number