www.deltadentalmn.org

Name ____

Address ____

City ______________________ State __________ Zip Code ____________

RE: Request for Cancelled Check(s)

Dear Customer:

Delta Dental has received your request for canceled check(s) copies. To begin processing your request, we require a $10.00 administrative fee for each check. Please complete the bottom portion of this letter and mail it with your check or money order, made payable to Delta Dental, to the address listed below:

Delta Dental of Minnesota
Accounting, Check Copy Request
500 Washington Ave South, Suite 2060
Minneapolis, MN 55415

We will begin the process of obtaining the cancelled check(s) as soon as we receive the requested information along with your payment. Please allow one-to-two weeks for processing.

- -

Contact Name ___________________________________ Phone Number _____________________

E-mail ____

How do you wish to receive your check copies?

☐ US Mail ☐ E-mail

Address ________________________________

City ________________________________

State _________ Zip Code ____________

E-mail (*if different than above*) ____

Anticipated reason for copy of check request:

☐ Embezzlement / Fraud

☐ Breach

☐ Reconcile Account

☐ Personal

Cancelled Check Bank Account Number	Issue Date	Cashed Date	Check Number	Check Amount
(Attach another document if additional space is needed)				