DELTA DENTAL

DELTA DENTAL OF IOWA
AUTHORIZATION AGREEMENT FOR EFT/CREDIT CARD PAYMENTS

I certify to the best of my knowledge the banking information given is not that of a foreign banking institution (located outside of the United States).

I grant Delta Dental authority to automatically charge my credit card or withdraw from my checking or savings account that was selected to pay my monthly premium payments. I further authorize Delta Dental to initiate adjustment entries to this account when necessary.

I understand if I choose this method of payment, my first month's premium will be withdrawn from my checking or savings account on the 5th calendar day of each month. If I choose credit card payment, I understand my first month's premium will be charged to my credit card on the first business day of each month beginning after the policy effective date.

This authorization is for the purpose of paying monthly premiums for dental and vision policies. I also understand the amounts are subject to change at least annually and Delta Dental will send written notification of such changes at least 60 days before the rate change takes effect.

This authority for payments is to remain in full force and effect until Delta Dental has received written notification from me of its withdrawal.

I understand in order to revoke my authorization provided or make changes to my payment information, I must contact Delta Dental of Iowa at TeamService@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, IA 50131-9010. You must provide Delta Dental 20 days notice prior to the requested termination date. Termination dates are always the last day of the month.

Delta Dental of Iowa SHALL BEAR NO LIABILITY OR RESPONSIBILITY FOR ANY LOSSES OF ANY KIND THAT YOU MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT, ANY DELAY IN THE ACTUAL DATE ON WHICH YOUR ACCOUNT IS DEBITED, OR YOUR FAILURE TO PROVIDE ACCURATE AND/OR VALID PAYMENT INFORMATION.

Bank Information:

Name of Financial Institution _____ Branch (If Applicable) _____

Account Type: ☐ Checking – please attach a voided check

☐ Savings – please attach a pre-printed deposit slip, or indicate:

Bank Routing Number _____ Account Number _____

Credit Card & Billing Information:

Card Type _____ Card Number _____ Expiration Date _____ ID (CVV) _____

Name on Card _____

Billing Address _____ City _____ State _____ Zip _____

Email Address _____ Phone Number _____

_____ _____

Print Name of Insured **Delta Dental ID Number**

_____ _____

Name & Signature of Accountholder/Cardholder **Date Signed**

Please complete and return this form to:
Delta Dental of Iowa P.O. Box 9010, Johnston, Iowa 50131-9010.