

FULLY INSURED GROUP ACCOUNT WITHDRAWAL AUTHORIZATION
FORM

As an officer having authority to withdraw corporate funds on behalf of:
_____ (name of group), I hereby authorize Delta Dental of Iowa to initiate debit entries to the account indicated below, and the financial institution named below, to debit the same to such account.

This authorization is for the purpose of paying Delta Dental for premiums due, and I understand that the amounts are subject to change based on eligibility changes.

Withdrawals will be made the first business day of every month.

Bank Information:			
_____ Name of Financial Institution		_____ Branch (if applicable)	
_____ Address of Financial Institution	_____ City	_____ State	_____ Zip Code
_____ Bank Routing Number		_____ Account Number	

This authority is to remain in full force and effect until Delta Dental of Iowa has received written notification, from an officer of this group, of its termination, in such time and manner as to afford Delta Dental and the above named financial institution a reasonable opportunity to act on it.

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

Group Name (Please Print)

Delta Dental Group Number

Signature and Title of Officer authorized to withdraw funds from bank

Date Signed

*If your banking institution is a foreign bank, please contact Delta Dental of Iowa for further instructions.

Please return to: Delta Dental of Iowa
 Attn: Kathi Erickson
 9000 Northpark Drive
 Johnston, IA 50131
 Phone 515/261-5515 Fax 888/264-0192