DELTA DENTAL

DELTA DENTAL OF IOWA
AUTHORIZATION AGREEMENT FOR EFT 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 hereby authorize Delta Dental of Iowa and the financial institution named to withdraw monthly premium payments from my checking or savings account that I selected. I further authorize Delta Dental of Iowa to initiate adjustment entries to this account when necessary.

I understand my first month's premium will be withdrawn from my checking or savings account immediately. I understand after the policy effective date, my premium will be deducted on the 28th of each month thereafter. This authorization is for the purpose of paying monthly premiums for Delta Dental of Iowa Individual and Family Dental Insurance. I also understand the amounts are subject to change at least annually and Delta Dental will send me 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 marketplace@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, IA 50131-9010. Termination of coverage must be initiated through the Individual Marketplace at www.healthcare.gov.

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)

Address of Financial Institution City State Zip Code

Account Type: ☐ Checking – please attach a voided check

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

Bank Routing Number _____

Account Number _____

Printed Name of Insured Delta Dental ID Number

Name & Signature of Cardholder Date Signed

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