DELTA DENTAL OF IOWA ACCOUNT WITHDRAWL AUTHORIZATION

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I understand my first month's premium will be withdrawn from my account starting on the 5th calendar day of the month of the policy effective date, and thereafter will be deducted on the 5th calendar day of each month. 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.

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 _____

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).

This authority for payments is to remain in full force and effect until Delta Dental of Iowa 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 via email at <u>marketplace@deltadentalia.com</u> or by sending a letter via postal mail to Delta Dental of Iowa P.O. Box 9010, Johnston, IA 50131-9010. The cancellation notice of coverage must be initiated through the Individual Marketplace at <u>www.healthcare.gov</u>.

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.

Please Print Name of Insured

Delta Dental ID Number

Name & Signature of Accountholder