DELTA DENTAL

DELTA DENTAL OF IOWA
AUTHORIZATION AGREEMENT FOR CREDIT CARD PAYMENTS

I grant Delta Dental of Iowa authority to automatically charge the credit or debit card I selected to pay my monthly premium payments. I further authorize Delta Dental of Iowa to initiate credit entries and adjustments to the account selected for any charges in error to my account.

I understand my first month's premium will be charged to my credit or debit card immediately. I understand after the policy effective date, my premium will be charged 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 coverage. 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 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 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.

Print 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.

(over, please)

Credit Card and Billing Information

Applicant First Name: _____

Applicant Last Name: _____

Card Type: _____

Name on Card: _____

Card Number: _____

Expiration Date: _____

Credit Card ID (CVV): _____

Billing Street Address: _____

Apt # or PO Box: _____

City: _____

State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____