# DELTA DENTAL OF IOWA
# ACCOUNT WITHDRAWAL AUTHORIZATION

_____

Name of Financial Institution

_____

Address of Financial Institution City State Zip Code

**Account Type:** ☐ Checking ☐ Savings

Bank Routing Number _____Account Number _____

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I understand my first month's premium will be withdrawn from my account starting on the 5th calendar day of the month of the policy effective date, and thereafter will be deducted on the 5th calendar day of each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

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 TeamService@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, Iowa 50131-9010. Please keep in mind that 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.

_____ _____

Printed Name of Insured Delta Dental ID Number

_____ _____

Name & Signature of Accountholder Date Signed