DELTA DENTAL®

Federal Government Programs

Electronic Funds Transfer (EFT) and Recurring Credit Card (RCC) Payment Authorization Form

By completing one of two sections below, you are authorizing a regularly scheduled withdrawal from your banking account or credit charges to your Visa®, MasterCard® or Discover® card. Each billing period, you will be charged the total amount of your premium due for that month, not to exceed your current monthly premium amount. The premium charges will appear on your credit card or bank statement. If your payment is rejected, your premium payment will be considered past due. You will be notified of your options for paying the past due amount. Failure to bring your account current could result in termination of your enrollment in the dental program. The form can be mailed or faxed to:

Delta Dental of California
Federal Government Programs Fax: 916-851-1559
Post Office Box 537007
Sacramento, CA 95853-7007

REQUIRED INFORMATION - Electronic Funds Transfer (EFT)

Customer Information

Subscriber Social Security Number:_____ Phone Number: ( )_____

Name: _____ Email Address: _____

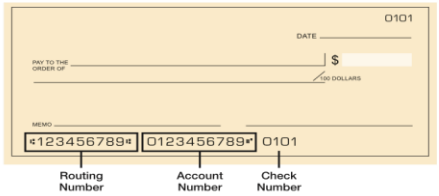
Address: _____

City, State, ZIP: _____

Name of Financial Institution: _____

Name on Bank Account: _____

☐ Checking ☐ Savings



Transit Routing (ABA) Number (always 9 digits): ☐☐☐☐☐☐☐☐☐

Bank Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Note: Please confirm with your banking institution that your account can accept Automatic Clearing House (ACH) debits and that you have provided the correct ABA for ACH transactions.

***Amount of payment**:* The appropriate premium amount will be deducted from your bank account on the 7th of every month or the next business day (depending on your financial institution).

***Right to stop automatic payments**:* You have the right to stop these payments at any time; however, doing so may adversely affect your dental insurance program enrollment. To stop your automatic payments, contact us at the address above. Phone cancellation must be received three business days before the next payment due date.

***Your responsibility**:* This EFT arrangement will be terminated if your account has insufficient funds or your bank refuses payment.

REQUIRED INFORMATION - Recurring Credit Card (RCC)

Credit Card Type: ☐Visa® ☐MasterCard® ☐ Discover®

Credit Card Number: _____ Expiration Date: _____ CVV:_____(3-digit number on back of card)

Cardholder Name: (as it appears on credit card) _____

***Amount of payment**:* The appropriate premium amount will be deducted from your credit card on the 5th of every month or the next business day (depending on your financial institution).

REQUIRED INFORMATION - Signature for EFT or RCC

***Your agreement below acknowledges you have read and understand the following important information:** I authorize Delta Dental to charge the credit card indicated on this authorization form or withdrawal from my banking account according to the terms outlined above. If the above-noted payment date falls on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Delta Dental in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This authorization is for payment of my monthly premiums. I certify that I am an authorized user of this credit card/banking account information and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.*

Signature: _____ Date: _____