DELTA DENTAL OF IOWA
ACCOUNT WITHDRAWAL AUTHORIZATION

I (we) hereby authorize Delta Dental of Iowa to initiate debit entries to the account indicated below, and the financial institution named below, to debit the same to such account. This authorization is for the purpose of paying monthly premiums for Delta Dental benefits, and I understand that the amounts are subject to change upon prior written notification to me at least 30 days in advance of any rate adjustment.

Monthly Withdrawal Date: _____ of the month

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**
(deposit slips are NOT acceptable for checking account information)

☐ Savings – please attach a pre-printed deposit slip and indicate for savings account only:

Bank Routing Number _____ Account Number _____

This authority is to remain in full force and effect until Delta Dental of Iowa has received written notification from me (us) of its termination. **Delta Dental requires a minimum of 20 days advance notice for termination of coverage in order to afford Delta Dental and the above named financial institution sufficient opportunity to process.**

I certify to the best of my knowledge that the banking information given above is not that of a foreign banking institution (located outside of the United States).*

_____ _____
Please Print Name of Insured Delta Dental ID Number (Social Security Number)

_____ _____
Signature of Payer Date Signed

*If your banking institution is a foreign bank, please contact Delta Dental of Iowa for further instructions.

Please sign & return the application with a voided check or pre-printed savings account deposit slip.

Please return the completed form to:
Delta Dental of Iowa PO Box 9010 Johnston, Iowa 50131-9010 or Fax to: 888-264-1433