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: ❒ 1st of month ❒ 5th of 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
❒ Savings – please attach a pre-printed deposit slip, or indicate:
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 in such time and manner as to afford Delta Dental and the above named financial institution a reasonable opportunity to act on it.

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

_____ _____
Signature of Insured Date Signed

Please return this completed form to:
Associations Marketing Group Inc.
1112 Maple St
West Des Moines, IA 50265

Have you attached a voided personal check or a pre-printed personal savings account deposit slip from your financial institution?

VER0806