DELTA DENTAL

DELTA DENTAL OF ILLINOIS
RECURRING CREDIT CARD CHARGE/ACH DEBIT AUTHORIZATION AGREEMENT

I hereby authorize Delta Dental of Illinois to charge/deduct the premium amount from the listed credit card or bank account on or about the 27th of each month for my monthly premium payment (if the payment method selected is monthly). I understand that the initial credit card charge or ACH debit to my account will occur immediately and if I have selected an annual payment option, the initial credit card charge or ACH debit will reflect the annual premium.

I agree that this authorization will remain in full force and effect until Delta Dental of Illinois has received written notification from me that I am terminating it. I agree to notify Delta Dental of Illinois in writing of any changes to my account information or termination of this authorization at least three (3) days (for ACH debits) or twenty-five (25) days (for credit card charges) prior to the next billing date. If I have enrolled on the Individual Marketplace, I understand that the cancellation notice must be initiated through the Individual Marketplace website.

I understand that Delta Dental of Illinois will notify me in advance of any changes to the premium amount. By completing this form, I hereby authorize Delta Dental of Illinois and the credit card company or bank identified below to process the credit card charges or ACH debits authorized here.

If I am not the insured person under this policy, I confirm that I am agreeing to pay this insurance premium on behalf of the insured person. Unless the insured person is a minor for whom I am a parent or legal guardian, I understand that any changes to the policy that may affect the premium amount will be communicated to the insured person only.

I agree that if I have any problems or questions regarding this authorization or my insurance policy, I will contact a Delta Dental of Illinois Consumer Direct Representative at 877-824-2776, 8:30 a.m. to 5:00 p.m. central time, Monday through Friday or by email at individualbilling@deltadentalil.com. I also agree that I will not dispute any charges with my credit card company or bank without first making good faith effort to resolve the dispute directly with Delta Dental of Illinois. I guarantee that I am the account holder for this bank account (for ACH debits) or legal card holder (for credit card charges) and that I am legally authorized to enter into this Recurring Credit Card Charge/ACH Debit Authorization Agreement with Delta Dental of Illinois.

For payment by credit card only: I authorize Delta Dental of Illinois to make any charges on a future policy I may purchase from Delta Dental of Illinois on the same credit card if I give verbal consent to Delta Dental of Illinois. Further, I understand that any transaction that is dishonored by my credit card company intended for payment to Delta Dental of Illinois may be assessed a $25 service charge by Delta Dental of Illinois.

For payments by bank account only: If my financial institution rejects an ACH debit from Delta Dental of Illinois due to insufficient funds, I understand and agree that Delta Dental of Illinois may in its discretion attempt to process the charge again within 30 days. I understand that if my bank dishonors any ACH debit requested by Delta Dental of Illinois under this agreement, Delta Dental of Illinois may assess me a $25 service charge, and Delta Dental of Illinois may collect that service charge by means of an ACH debit. I also understand that Delta Dental of Illinois may apply that service charge each time it resubmits an ACH debit request that is rejected (even if it is for the same unpaid amount as a previously-rejected ACH debit request).

DELTA DENTAL®

Payment Authorization Form

Insured First Name _____ Insured Last Name _____

(Insured is the primary member; the individual who holds the policy.)

Payor First Name _____ Payor Last Name _____

DDIL ID Number _____ Phone Number _____ Email _____

☐ I would like to add/update my credit card information (complete Credit Card Section below)

☐ I would like to add/update my Bank Account ACH Debit/Banking information (complete ACH Debit/Banking Section below)

☐ I would like to change my payment option from Bank Account ACH to Credit Card (complete Credit Card Section below)

☐ I would like to change my payment option from Credit Card to Bank Account ACH (complete ACH Debit/Banking Section below)

Credit Card and Billing Information (for Credit Card Charges)

Card Type: _____ Name on Card: _____

Card Number: _____

Expiration Date: _____ Credit Card ID (CVV): _____

Billing Street Address: _____ Apt # or PO Box: _____

City: _____ State: _____ Zip Code: _____

ACH Debit/Banking Information

Name of Banking Institution: _____

Banking Institution's City, State & ZIP Code: _____

Type of Account (Choose one): ☐ Checking ☐ Savings

Name on Account: _____

Bank Routing Number: _____

Bank Account Number: _____

I certify to the best of my knowledge that the banking information provided is not that of a foreign institution (located outside of the United States). My signature indicates that I agree to Delta Dental of Illinois's Recurring Credit Card/ACH Debit Authorization Agreement.

Signature of Insured _____ Date Signed

A parent/guardian signature is required for insureds who are under 18 years of age.

Parent/Guardian Name _____ Relation to the Insured

Please complete and return by fax to 630-369-0507 or mail to:
Delta Dental of Illinois Consumer Direct Team, 111 Shuman Boulevard, Naperville, IL 60563

BE SURE TO PRINT AND KEEP A COPY OF THIS FORM FOR YOUR RECORDS.