



Payment Authorization Form

- I would like to update my credit card information (complete Credit Card Section below)
- I would like to update my Bank Account EFT information (complete EFT Section below)
- I would like to change my payment option from Bank Account EFT to Credit Card (complete Credit Card Section below)
- I would like to change my payment option from Credit Card to Bank Account EFT (complete EFT Section below)

Credit Card Information

Card Type: [Visa] [Mastercard] [Discover] [American Express]

Name as it appears on credit card

Billing Address (Street, City, State, Zip Code)

Expiration Date: ____ month ____ year Security Code: _____

EFT Information

Name of Financial Institution

Financial Institution's City, State & ZIP Code

Type of Account (Choose one): Checking Savings

Name on Account

Bank Routing Number

Bank Account Number

I hereby authorize Delta Dental of Illinois to withdraw funds from the above-listed bank account or debit my credit card for the payment of my dental insurance premiums.

Signature

Date

I understand that any transaction that is dishonored by my bank/credit card intended for payment to Delta Dental, may be assessed a \$25.00 service charge by Delta Dental of Illinois.

Please email completed form to individualbilling@deltadentalil.com.