DELTA DENTAL®

Federal Government Programs

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

By completing one of two payment options below, you are authorizing a regularly scheduled withdrawal from your bank 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 bank or credit card 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. Mail or fax the completed form to Delta Dental at the address below, or register for the secure Consumer Toolkit® and log on to complete your information online.

Delta Dental of California
Federal Government Programs
Post Office Box 537007
Sacramento, CA 95853-7007

Fax: 916-851-1559
Consumer Toolkit®: **ddfgptoolkits.com**

REQUIRED INFORMATION – Customer Information

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

Name: ____________________ Email Address: ____________________

Address: ____________________

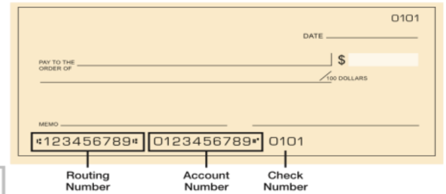
City, State, ZIP: ____________________

Electronic Funds Transfer (EFT)

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.

Recurring Credit Card (RCC) Payment

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

Credit Card Number: ____________________ Exp. Date: __________ CVV: __________ (3-digit number on back of card)

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

REQUIRED INFORMATION – Acknowledgement/Signature for EFT or RCC

Amount of payment: *For EFT* - The appropriate premium amount will be deducted from your bank account on the sixth of every month or the next business day, depending on your financial institution. *For RCC* – The appropriate premium amount will be deducted from your credit card on the sixth of every month or the next business day, depending on your financial institution

Right to stop automatic payments: You have the right to stop automatic 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/written notice of cancellation must be received three business days before the next payment due date. You must provide information for an alternate payment method (i.e., a new bank account or credit card) at the time you cancel your current payment method. Failure to do so in a timely manner could result in the termination of your account and a 12-month re-enrollment lockout.

Your responsibility: This EFT or RCC payment arrangement will be terminated if your financial institution refuses payment due to insufficient funds or other reason. Second attempts to deduct payment will not be made using the same payment method information. If we receive information for a new payment method after the attempt to deduct payment has been refused, we will use the new information provided to attempt a deduction for the past-due balance.

I authorize Delta Dental to charge the credit card indicated on this authorization form or withdraw funds from my bank account for payment of my monthly dental program premiums according to the terms outlined above. If the above-noted payment date for EFT or RCC 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 by phone or in writing, and I agree to notify Delta Dental by phone or in writing of any changes in my account information or termination of this authorization at least three days prior to the next billing date. I certify that I am an authorized user of this bank account/credit card and that I will not dispute the scheduled payments with my financial institution provided the transactions correspond to the terms indicated in this authorization form.

Signature: ____________________ Date: ____________________