



4818 Starkey Road
Roanoke, VA 24018

Automatic Draft of Monthly Premiums

I authorize Delta Dental of Virginia to deduct monthly premium payments from the account identified below.

Bank Name: _____

Address of Bank: _____

City, State, Zip: _____

Account Number: _____

Transit/ABA Number: _____

The debit entry will be initiated on the 25th of each month and shall not exceed the monthly amount due based upon the coverage selected. This authority is to remain in full force and effect until Delta Dental of Virginia receives written notification to terminate monthly payment by bank draft. The written notification must be received by Delta Dental of Virginia thirty (30) days prior to the monthly draft discontinuation effective date.

Name (Please Print): _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Social Security Number: _____

Authorized Signature: _____

Date: _____

