Automatic draft of monthly premiums

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

Bank name ____

Bank address ____

City, state, ZIP code ____

Transit/ABA number____________________ Account number____________________

The debit entry will be initiated on the first business day of the month for the current month's premium. This authorization will remain in effect until Delta Dental of Virginia receives written notification to terminate monthly payments by bank draft. Written notification must be received by Delta Dental of Virginia 30 days prior to the monthly draft discontinuation effective date.

Company name______________________________ Group number ______________

Address____

City, state, ZIP code ____

Phone number ____

Authorized signature______________________________ Date____/____/_____

Instructions for automatic draft

To participate in the automatic draft program, an authorization form must be signed allowing us to draft your company's account. Complete and submit the attached form via email to billing@deltadentalva.com or fax at 540.776.8109.

Once the authorization form is received and your account is set up, the first draft may be a test of the account information. Delta Dental will contact you if we have any issues with this process. If you provide a Company ID to your financial institution for drafts to be completed, **note that the Company ID for Delta Dental of Virginia is 4540844477.** *Contact Billing and Eligibility at 800.237.6060 if you have questions.*