DELTA DENTAL OF IOWA
FULLY INSURED GROUP ACCOUNT WITHDRAWAL AUTHORIZATION

As an officer having authority to withdraw corporate funds on behalf of: ______________________________ (name of group), I hereby authorize Delta Dental of Iowa to initiate debit entries to the account indicated below, and the financial institution named below, to debit the same to such account.

This authorization is for the purpose of paying Delta Dental for premiums due, and I understand that the amounts are subject to change based on eligibility changes.

Withdrawals will be made the first business day of every month.

Bank Information:

____

Name of Financial Institution Branch (If Applicable)

Account Type: ☐ Checking – please attach a voided check

☐ Savings – please attach a pre-printed deposit slip, or indicate:

Bank Routing Number____________________________ Account Number________________________________

This authority for payments is to remain in full force and effect until Delta Dental has received written notification, from an officer of this group, of its withdrawal. You must provide Delta Dental 20 days notice prior to the requested termination date. Termination dates are always the last day of the month.

I certify to the best of my knowledge that the banking information given above is not that of a foreign banking institution (located outside of the United States).*

____ ____

Group Name (please print) **Delta Dental Group ID Number**

____ ____

Signature & Title of Officer Authorized to Withdraw Funds **Date Signed**

*If your banking institution is a foreign bank, please contact Delta Dental of Iowa for further instructions.

Please complete and return this form to:
Delta Dental of Iowa Attn: Kathi Bieghler
9000 Northpark Drive, Johnston, Iowa 50131-9010.

Phone: 515-261-5515 Fax: 888-264-0192 Email: kbieghler@deltadentalia.com

2725-A10050 11/2021